An Interim Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals: Phase II, Part I

September 2008

Submitted by the Health Professions Regulatory Advisory Council (HPRAC)
September 8, 2008

Hon. David Caplan
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister:

The Health Professions Regulatory Advisory Council is pleased to present its second report on interprofessional collaboration as requested in the letter sent to us on June 28, 2007. The goal of high-quality, patient-centred care in a sustainable health system is at the centre of our advice.

We include recommendations to ensure that the regulatory framework for health professionals is flexible and adaptable, while strengthening the accountability of the health regulatory colleges and their members. The recommendations also propose changes to the scope of practice of the professions of pharmacy, midwifery, dietetics and physiotherapy. These changes will enable members of these professions to work to the utmost of their knowledge and skills, advance professional teamwork, and provide better results for patients. Improving collaboration among health regulatory colleges and among health professionals is one way to ensure that patients have the highest quality, safe, comprehensive and coordinated care.

We want to thank the hundreds of people and organizations who provided information and analysis for this report, and in particular Ontario’s health colleges and professional associations whose scope of practice were reviewed in this phase. They worked assiduously to prepare detailed information, engage others in discussions, participate in HPRAC’s consultations, respond to HPRAC’s questions and meet demanding deadlines.

Our final report on interprofessional collaboration in 2009 will speak to potential changes to legislation and regulation, structures and processes over the longer term that will make a difference to the way people receive care, and how our health professionals can work to their full capacity.

Yours truly,

Barbara Sullivan, Chair
Peter Sadlier-Brown, Vice-Chair
Kevin Doyle
Mary McDonagh

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# Interprofessional Collaboration

## Phase II

### Regulation of Health Professions in Ontario

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>HPRAC’s Central Response</td>
<td>1</td>
</tr>
<tr>
<td>Environmental Scan: Health Care in Transformation</td>
<td>4</td>
</tr>
<tr>
<td>An Evolving Legislative Framework</td>
<td>7</td>
</tr>
<tr>
<td>How HPRAC Reviews a Profession’s Scope of Practice</td>
<td>9</td>
</tr>
<tr>
<td>How HPRAC Conducted its Reviews</td>
<td>12</td>
</tr>
<tr>
<td>An Enabling Regulatory Framework</td>
<td>14</td>
</tr>
<tr>
<td>2. Review of the Scope of Practice of Pharmacy</td>
<td>19</td>
</tr>
<tr>
<td>3. Review of the Scope of Practice of Midwifery</td>
<td>79</td>
</tr>
<tr>
<td>4. Review of the Scope of Practice of Dietetics</td>
<td>131</td>
</tr>
<tr>
<td>5. Review of the Scope of Practice of Physiotherapy</td>
<td>155</td>
</tr>
<tr>
<td>APPENDIX A – Summary of Recommendations</td>
<td>187</td>
</tr>
<tr>
<td>APPENDIX B – Summary of Implementation Recommendations</td>
<td>193</td>
</tr>
</tbody>
</table>
Introduction

The Minister’s Request

On June 28, 2007, the Minister of Health and Long-Term Care, the Honourable George Smitherman, requested the Health Professions Regulatory Advisory Council (HPRAC) to:

Recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges, beginning with the development of standards of practice and professional practice guidelines where regulated professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession.

The Minister also asked that HPRAC:

Take into account, when controlled acts are shared, of public expectations for high quality services, no matter which health profession is responsible for delivering care or treatment.

This document is HPRAC’s second report on its work in response to the Minister’s request on interprofessional collaboration between health colleges.

HPRAC’s Central Response

In this report, HPRAC presents recommendations to ensure that the regulatory framework for health professionals is flexible and adaptable, while strengthening the accountability of the health regulatory colleges and their members. The recommendations also propose changes to the scope of practice of the professions of pharmacy, midwifery, dietetics and physiotherapy. These changes will enable members of these professions to work to their maximum competencies, and to collaborate more effectively with other professionals in providing care. Interprofessional collaboration is not an end in itself. It is a means to the goal of high-quality, patient-centred care in a sustainable health system. HPRAC recognizes that there are many facets to health system reform, and that regulatory solutions represent only one element. In a number of instances where HPRAC has identified barriers, steps that do not require statutory or regulation changes are proposed.

About HPRAC

HPRAC is an independent agency of the Government of Ontario created in 1993 under the Regulated Health Professions Act, 1991 (RHPA) to provide advice to the Minister of Health and Long-Term Care on matters related to the regulation of health professions in Ontario. Its mandate includes providing advice on:
Chapter 1 – Introduction

- Whether unregulated health professions should be regulated,
- Whether regulated health professions should no longer be regulated,
- Amendments to the RHPA and related Acts, and their regulations,
- Matters concerning the quality assurance programs of the colleges,
- Any matter related to the regulation of health professionals, referred to HPRAC by the Minister, and
- The effectiveness of each college’s patient relations program.

The Minister relies on recommendations from HPRAC as an independent source of information, analysis and advice in the formulation of public policy. In providing its advice and conducting its affairs, HPRAC is independent of the Minister, the Ministry of Health and Long-Term Care, the colleges, health care associations and others who have an interest in issues on which advice is provided.

**Primacy of the Public Interest**

The purpose of regulation is the advancement of the public interest, and this is the first principle or fundamental ground upon which everything else is founded. It is a basic moral precept that has become enshrined in the ethical codes of the health professions, and enforced by professional regulation. HPRAC is resolved to keep this principle foremost in mind throughout its deliberations.

**HPRAC’s Approach to Formulating its Advice**

In March 2008, HPRAC submitted its first interim report to the Minister on interprofessional collaboration, highlighting its activities to date including stakeholder workshops, release of a discussion guide, and posting of literature and jurisdictional reviews. In its interim advice, HPRAC recommended specific mechanisms for improving collaboration among the professions that practice acupuncture and psychotherapy. As well, HPRAC provided an initial overview of matters that affect people who receive eye care from professionals in Ontario.

In addition, the interim report described the next steps in the project – such as analysis of responses to the discussion guide, further consultations, and reviews of the scope of practice of professions whose work fundamentally demands interprofessional relationships.

This document presents the results of four scope of practice reviews, specifically for:
- pharmacists
- midwives,
- dietitians, and
- physiotherapists.

It will be followed by a final report on interprofessional collaboration that will incorporate scope of practice reviews for two other professions:

- medical radiation technologists, and
- medical laboratory technologists.

The final report will present HPRAC’s overall conclusions and recommendations for encouraging interprofessional collaboration among professions in Ontario’s health care system. It will speak to
Chapter 1 – Introduction

HPRAC’s conclusions about new paradigms for the delivery of efficient and effective patient-centred care in Ontario, and will explain how formal or informal organizational structures and processes can be shaped to facilitate collaboration among regulatory bodies and closer working relationships among professionals who provide clinical care.

Links with Other Questions

The request on interprofessional collaboration was one of a series of eight items that the Minister referred to HPRAC in his June 2007 letter. The Minister described all these items as “important matters” that support the government’s commitment to “ensuring that the health profession regulatory system keeps pace with and supports the health care needs of Ontarians.”

The other items are:

- scope of practice of registered nurses in the extended class (nurse practitioners),
- authority for non-physician professions to prescribe and/or use drugs in the course of their practice, and a framework and process for changes to drug regulations for non-physician prescribers,
- regulation of diagnostic sonographers,
- consideration of an association model for personal support workers,
- regulation of dental assistants,
- regulation of paramedics and emergency medical attendants, and
- regulation of chiropody and podiatry.

Issues tied to interprofessional collaboration were central to HPRAC’s review of nurse practitioners’ scope of practice, which was submitted to the Minister in March 2008. Interprofessional collaboration will also be in the forefront as HPRAC completes its work on the other requests for advice. In all of these projects, HPRAC will look for common mechanisms to facilitate collaboration across professions to the maximum extent possible, rather than concentrating exclusively on instruments that are specific to one profession.

Phase One Overview

To briefly recap activities leading to the interim report in March 2008, HPRAC completed the following tasks in the first phase of the interprofessional collaboration project:

- sponsored two workshops in October 2007 with representatives from health colleges and associations representing health care professionals, facilities and providers to assess interprofessional issues and identify barriers to collaboration as well as potential solutions,
- conducted and published a literature review to gather information on the current evidence and thinking about interprofessional collaboration,
- conducted and published a jurisdictional review to learn about the steps other jurisdictions are taking and mechanisms that Ontario could adopt or adapt to advance interprofessional collaboration among health colleges,
- prepared and published a discussion guide for broad distribution to members of the public, health care professionals, regulatory bodies, educators, health care providers, associations and others,
Chapter 1 – Introduction

- reviewed options for specific professions, including the new professions of traditional Chinese medicine and psychotherapy, where collaboration in the development of standards of practice is expected, and
- commented on concerns in professions providing eye care.

As noted in the discussion guide and the interim report, five key themes were highlighted at the workshops and in the literature and jurisdictional reviews:

- A growing number and a variety of interprofessional models of clinical care are emerging across the care continuum.
- While only a limited number of studies have been published, the volume of research on the benefits of interprofessional patient care is increasing. Assessments show that clients and patients of interdisciplin ary collaborative care have a high level of satisfaction with the results of this type of care. Studies in various countries indicate positive outcomes in quality of life and care with a range of patient and client types.
- Commitment and progress in developing interprofessional education, particularly at the postgraduate level, is apparent.
- Few legislative and regulatory initiatives to support interprofessional collaboration, including a role for health regulatory bodies, have been recorded and evaluated.
- Some developments related to interprofessional collaboration in other Canadian jurisdictions and internationally – including the United States, Britain, Denmark, Australia, New Zealand and parts of the European Union – are useful.

HPRAC will return to the above themes in its final report on the interprofessional collaboration project. In that report, HPRAC will offer findings and recommendations on a range of mechanisms, structures and tools that could be deployed to foster interprofessional collaboration in Ontario.

Environmental Scan: Health Care in Transformation

In its previous reports to the Minister, HPRAC has identified the fast-paced changes in health care delivery that have occurred since the RHPA was first introduced in Ontario in 1991, including a shift to multidisciplinary and collaborative care. In its New Directions report of April 2006, HPRAC said that:

Facilitating this trend, through provisions in health professions regulation is essential. It is also vital that our professionals have the flexibility to provide treatment and patient care to the fullest extent of their qualifications and training, and that they are able to respond effectively to changes in technologies and to new methodologies. Further, colleges need the appropriate tools and flexibility to fulfill their responsibilities while also building public confidence in self-regulation.¹

There are increasing challenges to designing and developing a sustainable health care system. Some of the influences that impact public policy include:

Chapter 1 – Introduction

A Changing Society

Demographic change has profound implications for health needs and the health care system that exists to meet them. Ontario’s population is growing, aging and becoming more urbanized and more diverse.2

The population is expected to increase by 3.1 million by 2025, with growth coming primarily from immigration and concentrated largely in the Greater Toronto Area. While the GTA’s population is expected to grow by 33 percent, central, eastern and south western Ontario are expected to experience population declines. According to the 2001 census, nearly a quarter of Ontario’s population speaks one of more than 100 languages other than English.

The share of seniors in the Ontario population is forecast to rise sharply from 12.9 percent in 2005 to 19.4 percent in 2025, as the baby boom generation ages and life expectancies continue to rise. The expanding senior population brings with it a higher incidence of chronic diseases, greater need to care for patients with multiple complex conditions and more emphasis on resources to help seniors remain in their own homes.

Health Human Resources Shortages

As Ontario’s population ages, so does its health care workforce. For example, 19 percent of practicing physicians are over the age of 60, and 11 percent are over 65.3 In the nursing profession, 2007 statistics4 show that one quarter of registered nurses in the general class are 55 years or older and 11 percent are 60 or older.

Attracting and retaining physicians, nurses, technologists and other health professionals is already a challenge, not only in northern, rural and remote areas but, increasingly, in urban centres. Ontario is experiencing a shortage of human resources across many health professions. This challenge will intensify as demographic trends unfold, with shortages of health professionals predicted to continue for at least the next two decades. During this period, Ontario’s growing and aging population will rely on a constrained supply of professionals to provide necessary care.

Changing Technology and Clinical Practice

These are times of fast-paced change in health care delivery. Digital communications have exerted a wide-ranging influence on everything from health records to telemedicine and the Internet has empowered consumers with access to information to maintain health and participate in their own care in new ways.

At the same time, advanced technologies such as magnetic resonance imaging (MRI) permit earlier and more reliable diagnosis. Less invasive surgeries, more day surgery, more ambulatory care and the substitution of drug therapies for surgery have reshaped clinical practice. Innovations in pharmacology have revolutionized treatment of diseases such as HIV/AIDS, cancer, mental illness and cardiac care. As a result, health services that were previously provided in hospitals can now be delivered in the community

or provided as outpatient services. As patients move between settings – for example, from hospitals to their own homes or long-term care facilities – continuity of care is a priority to keep the focus on patient needs.

These rapid advances in technology and clinical practice place enormous demands on professionals to keep pace – demands that must be met not only by working to the maximum extent of their scopes of practice, but also by developing new competencies. They also mean that health professionals can communicate with each other more efficiently, and that patients can benefit from the shared knowledge of health professionals who can work together to address their needs. There is also an intense public demand for increased attention to issues of patient safety and patient-caregiver communication.

The advance of technology will continue: genomics, and medical applications of robotics and nanotechnology will bring exponential changes to the practice of medicine and delivery of health care.

**Interprofessional Collaboration**

These well-established trends in society in general and health care in particular have combined to put a new focus on health human resources. It is clear that innovation in their use, development and management is essential. Interprofessional collaboration is a promising strategy for making the most of valuable human resources in the health care system.

In May 2006, the Ministry of Health and Long-Term Care announced the creation of HealthForceOntario – a multi-year strategy to give Ontario the right number and mix of health care providers. It includes initiatives to predict Ontario’s health human resource requirements, develop new provider roles to meet changing needs, reshape educational programs to develop people with the right knowledge, skills and attitudes, and recruit and retain health professionals by competing effectively with other jurisdictions.

A key priority in HealthForceOntario is to place more emphasis on interprofessional collaborative care to make better use of vital health human resources. In July 2007, the Interprofessional Care Steering Committee submitted a report, *Interprofessional Care: A Blueprint for Action in Ontario*. It defines interprofessional care as “the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.”

As the report observes:

> The health care system is gradually being transformed to ensure that the patient is at the centre, delivery is timely, care is safe, continuity is maintained and access is guaranteed. Improved collaboration and teamwork are expected to help caregivers manage increasing workloads, reduce wait times and reduce the likelihood of adverse reactions to care.”

It calls for the incorporation of interprofessional care into existing legislation, systems and infrastructure and notes that recent initiatives such as family health teams, wait-times management and Local Health Integration Networks (LHINs) all depend on a model of interprofessional care.

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6 Interprofessional Care: A Blueprint for Action in Ontario, p. 7.
7 Ibid
Chapter 1 – Introduction

Following the Blueprint report, an Interprofessional Care Strategic Implementation Committee was established to implement key elements of the report. The Committee’s mandate is to:

- Provide guidance to government in managing the implementation of interprofessional care at the system, organizational, education, practice and policy levels,
- Serve as a key resource for interprofessional care implementation by establishing partnerships, facilitating dialogue and promoting best practices of IPC models and concepts, and
- Establish and direct working groups to address technical structures and processes that will provide the tools to support and facilitate interprofessional care such as approaches to knowledge transfer and evaluation.  

The Committee's work will help lay the foundation for a culture of collaborative, patient-focused care in the province. HPRAC’s work in the regulation of health professionals, in parallel with that of the Implementation Committee, will inform its work.

An Evolving Legislative Framework

The RHPA governs Ontario’s health professions generally. It restricts the performance of certain controlled acts, which could cause serious harm if not performed competently, to members of regulated professions. It also contains a Procedural Code that governs the functioning of the health profession colleges, including such matters as the registration of health professionals, complaints, discipline, quality assurance and patient relations.

The RHPA allows overlapping scopes of practice, so that more than one profession is authorized to perform some of the same or similar controlled acts and to set standards for the performance of those acts. All professions that share the same or similar controlled acts are expected to do so by providing the highest quality of patient care.

The regulation of health professions is an ongoing, evolving process. In April 2006, HPRAC provided extensive advice to the Minister through its report, Regulation of Health Professions in Ontario: New Directions. In New Directions, HPRAC recommended structuring Ontario’s health professions’ regulatory environment to support innovative ways to deliver health care to patients – including a stronger focus on interprofessional care.

HPRAC recommended that the RHPA be amended to include new objectives for the regulatory colleges that related specifically to collaboration among the colleges. Following HPRAC’s report, the Health System Improvements Act, 2007 added three new objects to the RHPA’s Procedural Code to support interprofessional collaboration. New mandates were enacted for each health regulatory college to:

- promote and enhance relations between the college and its members, other health profession colleges, key stakeholders and the public,
- promote interprofessional collaboration with other health profession colleges, and
- develop, establish and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

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8 See http://www.healthforceontario.ca/WhatIsHFO/AboutInterprofessionalCare/StrategicImplementationCommittee.aspx
Distinction between Interprofessional Care and Collaboration

It should be noted that interprofessional collaboration – the subject of the Minister’s request to HPRAC – is a broader concept than interprofessional care.

Interprofessional care takes place at the clinical level. It is about teamwork among health professionals from different disciplines to provide comprehensive, quality care to patients, whether in institutions or in the community. Interprofessional collaboration refers to cooperation, not only among practitioners, but also among the health profession colleges of which they are members. Interprofessional collaboration takes place at the regulatory level, as well as at the clinical level. One objective of regulatory collaboration is to foster interprofessional care. Another is to ensure that the standards of practice set by one college are workable for members of other colleges. Other reasons for colleges to collaborate include improving the overall operation of the regulatory system, increasing access to health services, and making optimal use of professional skills and competencies.

Goals of Interprofessional Collaboration

To provide a context for its work, HPRAC developed a statement on interprofessional collaboration to convey its interpretation of what the Minister’s question implies. This statement elaborates on the goals of interprofessional collaboration. HPRAC’s view is that measures should be developed to assist health profession colleges and their members to work together to:

- improve patient care and facilitate better results for patients,
- protect the public interest and ensure the highest standards of professional conduct and patient safety,
- regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest,
- optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services,
- ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment, and
- enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability.

HPRAC’s assessment began with the premise that strengthening collaboration among the health professions should be grounded in several underlying principles:

- meeting public expectations for improved access to high quality, safe services and patient-centred care,
- optimizing the contribution of all health professionals,
- rigorous standards for the regulation of health professionals,
- using resources efficiently,
- sustaining the health care system, and
- maintaining self-regulation.
A Focus on Scopes of Practice

As part of its work on interprofessional collaboration, HPRAC has completed reviews of the scope of practice for four professions, with two more to be undertaken later in the project. The findings of the first four reviews are presented in this report.

These studies have been carried out in response to the Minister’s request for advice on collaboration between colleges to develop standards of practice where professions share the same or similar controlled acts. More broadly, HPRAC has undertaken these scope of practice reviews because of the imperative to realize the full potential of all health professionals to contribute to the quality of care.

A health care system where all health professionals can function to the fullest extent of their training and capability as part of an integrated and collaborative team is a key to improving access to seamless, effective, patient-centred care. Collaboration among health profession colleges, as well as among their members, is essential to harness the full capabilities of all practitioners to deliver the best possible service to patients.

Enabling professionals to perform more tasks independently, consistent with their competence, will enhance their ability to work with others as part of the health care team. Existing professions will be able to take on new or altered roles in a collaborative environment as barriers that keep them from practicing to their full potential are removed.

Increased transparency and clarity about scopes of practice will raise awareness of the abilities of various professions and open up new collaborative possibilities in care settings. It is HPRAC’s expectation that the renewal and refinement of scopes of practice will promote mutual recognition of and respect for professional roles, creating a climate for the optimal use and mix of health professionals. In HPRAC’s view, the revision of professional scopes of practice at the regulatory level is one important way to strengthen interprofessional collaboration at the clinical level.

The professions reviewed in this report, along with nurse practitioners, which HPRAC reported to the Minister on March 31, 2008, and those that will be reviewed in the coming months, are those whose members work in settings where interprofessional relationships already exist and appear to have significant potential for further development. They also play key roles in achieving priorities such as better management of chronic disease, improved access to primary care, aging at home strategies and reduced wait times.

How HPRAC Reviews a Profession’s Scope of Practice

When preparing its report on the scope of practice of nurse practitioners, HPRAC carefully considered the approach to be taken and issued a document on this subject in spring 2007. The discussion paper explained the definition of a scope of practice and outlined the process for conducting a review. It served as a roadmap for the nurse practitioners’ project and has been followed for each of the reviews that are the subject of this report.
What is a Scope of Practice?

As HPRAC has emphasized, and as the Health Council of Canada has observed, the scope of a profession cannot be encompassed entirely in one document.\(^\text{10}\)

In Ontario, the legislative framework for the health professions includes the *RHPA* and a series of profession-specific Acts. The *RHPA* contains provisions on the duties and powers of the Minister, the role of HPRAC, a list of controlled acts and other prohibitions. It also includes a Procedural Code governing the operation of regulatory colleges.

Each profession-specific Act includes a scope of practice statement. However, the statutory statement is only the beginning. Each profession-specific Act also includes the controlled acts the profession is authorized to perform (if any), the title or titles restricted to members of the profession and other provisions.

When HPRAC reviews a professions’ scope of practice, it analyzes the scope of practice statement and the controlled acts authorized to the profession. In addition, HPRAC examines the implications of the harm clause contained in the *RHPA*, which prohibits everyone except health professionals acting within their scope of practice from treating or giving advice with respect to health where serious physical harm may result.\(^\text{11}\) As well, HPRAC considers regulations developed under the profession-specific Act and other legislation that may affect the profession. Also examined are the standards of practice, guidelines, policies and by-laws developed by the regulatory college.

All of these elements combined determine the profession’s scope of practice. HPRAC has considered the full range of these elements in conducting its review of the scope of practice of the four professions.

**Individual vs. Professional Scope of Practice**

As well as referring to the clinical activities authorized to a profession, the term “scope of practice” is employed by regulatory agencies to define the procedures, actions and processes that a specific registered individual may perform. This individual scope of practice is based on, among other things, the registrant’s education, clinical experience and demonstrated competency. While a professional scope of practice describes the full scope of activity open to the profession as a whole, an individual scope of practice describes the scope of activity within which individual practitioners may conduct their practice.\(^\text{12}\) The individual scope of practice generally represents a subset of the larger professional scope of practice.

**The Review Process**

In developing its advice to the Minister, HPRAC attempts to ensure that its processes are thorough, timely and efficient and reflect principles of fairness, transparency and evidence-based decision-making. HPRAC undertakes research to secure evidence for its conclusions, drawing on organizations and individuals with expertise in the matters under consideration, both in Ontario and elsewhere. HPRAC tailors its consultation process to the specific matters under consideration. Given the wide interest in, and

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\(^{11}\) s. 30. Effective June 4, 2009 or on an earlier day to be established by proclamation, this section will be amended by striking out “physical” and substituting “bodily”. See *Health System Improvements Act*, 2007, S.O. 2007, c. 10, Sched. M, ss. 6 and 75 (1).

the significant implications of, the scope of practice issues under examination, HPRAC conducted an
extensive program of research and consultation for these four reviews.

HPRAC has developed a series of criteria to be used in assessing proposals to change a profession’s scope
of practice. These criteria are as follows\(^\text{13}\):

1. **Relevance to the Profession**

   The profession should demonstrate that the requested change in scope of practice is rationally related
to the practice of the profession and to the qualifications and competencies of members of the
profession. It should describe whether the proposed change to the scope of practice provides
recognition and authority for existing competencies, or seeks to expand the scope of the practice of
the profession.

2. **Risk of Harm**

   If the proposed change in scope of practice presents an increased risk of harm to the public, the
profession should demonstrate how it intends to mitigate that risk, and how the training and
competencies of members provide assurance that patients or clients will be cared for within evidence-
based best practices.

3. **Relevance to the Health Care System and Relationship to other Professions**

   The profession should demonstrate that a change in the scope of practice is consistent with evolution
in the health care delivery system, and particularly with changing dynamics among health
professionals who work in integrated, team-based and collaborative care models.

4. **Sufficiency of Supervision and Need for Autonomy**

   The profession should demonstrate that a change in the scope of practice is the most appropriate,
effective and efficient means to provide clinical and patient care services, that delegation or
supervisory structures currently available are inadequate, and that the authority for independent or
autonomous professional activity is required in the provision of patient care.

5. **Body of Knowledge**

   The profession should show that there is a systematic body of knowledge within the profession to
perform the activities being requested and that this change in role is broadly accepted within the
profession.

6. **Education and Accreditation**

   Members of the profession should demonstrate that they have, or will have, the knowledge, training,
skills and experience necessary to carry out the duties and responsibilities involved in the proposed
change in scope of practice. In addition, the profession should demonstrate that the education
programs are appropriately accredited by an approved accreditation body.

7. Leadership’s Ability to Favour the Public Interest

The profession’s leadership should show that it will distinguish between the public interest and the profession’s self-interest and will favour the public interest at all times.

8. Profession’s Support and Willingness to Comply with Regulation

The profession should demonstrate that it supports the proposed change in scope of practice and that compliance with regulatory requirements is likely among its members.

9. Economic Impact

The profession should demonstrate an understanding and appreciation of the economic impact of the proposed change in scope of practice for the profession, the public and the health care system.

10. Public Need

The profession should demonstrate that a significant public need would be met through the proposed change in scope of practice.

HPRAC has developed a detailed questionnaire to elicit information relevant to these criteria from a profession seeking a change in its scope of practice.

**How HPRAC Conducted its Reviews**

As HPRAC commenced its reviews of the professions included in this report, a number of overarching considerations were foremost in mind. These included:

- the fundamental importance of the public interest,
- the relevance to these professions of a new regulatory framework, and
- the impact of overlapping scopes of practice on interprofessional collaboration.

**Research and Consultation**

On April 1, 2008 HPRAC wrote to each of the professions under review and requested that they complete a detailed questionnaire addressing scope of practice matters in the context of interprofessional collaboration. These submissions were posted on HPRAC’s website in early July and interested parties were invited to make written submissions in response to these proposals by mid-August.

In August, HPRAC held meetings in five cities – Ottawa, Windsor, Thunder Bay, Sudbury and Hamilton – to gather information about the impact of the proposed changes on health care delivery in all regions of the province. Participants included practitioners in the four professions under review in this phase, as well as representatives from other professions and from local health service providers and organizations, such as family health teams, community health centres, Community Care Access Centres, long-term care homes, hospitals and Local Health Integration Networks.
HPRAC also held further meetings in Toronto that brought together representatives of the four professions under review and representatives of other affected professions. Key informant interviews took place with subject experts and with educators in each of the four professions.

In addition, HPRAC received more than 200 written responses to the proposals from individuals and organizations, and each was analysed in HPRAC’s review. All responses are posted on HPRAC’s website.

HPRAC completed reviews of the literature on the scope of practice for each of the four professions to compile the latest evidence and analysis. Jurisdictional reviews were also conducted for each profession to determine what could be learned from the experience in other provinces and internationally. The literature and jurisdictional reviews for each profession are posted on HPRAC’s website.

In all, more than 300 individuals and organizations, representing thousands of people, participated in the consultation process. HPRAC deeply appreciates this generous contribution and believes it has produced a solid base of evidence as a foundation for recommendations to the Minister.

Considerations Guiding HPRAC’s Analysis

At the outset, HPRAC adopted a series of considerations to frame its review of the scopes of practice for pharmacy, midwifery, dietetics and physiotherapy:

1. Recommendations to change a profession’s scope of practice for the professions must be in the best interest of the public and protect the public from risk of harm. They must also satisfy HPRAC’s criteria for reviewing scopes of practice.

2. The Minister’s request for advice provides an opportunity to review and make recommendations to the legislative and regulatory framework underpinning the scopes of practice for the four professions with a focus on:
   - Removing barriers to competent practice,
   - Supporting effective utilization of health practitioners across the care continuum,
   - Enabling collaboration at the regulatory and clinical levels, and
   - Considering Ontario’s approach to regulating health professions relative to other jurisdictions.

3. The professions’ submissions are a starting point for reviewing the scopes of practice. Recommendations and decisions on the scope of practice reviews should be further informed by system needs, evidence-based research, experience in other jurisdictions, and the advice of experts and interested individuals and organizations.

4. The review of the scopes of practice must include consideration of health human resource challenges and the need to:
   - Reduce barriers to continuity of care,
   - Improve access to patient-centred care, and
   - Clarify roles.

5. The diversity of the professions requires a legislative and regulatory framework that will provide the colleges with the authority, flexibility, and tools to regulate their members effectively.
6. Changing legislation or regulation is not necessarily the only or best way to address barriers facing a profession.

Conclusions Reached in the Reviews

As a result of its analysis, research and consultations, HPRAC has made a number of recommendations for revisions to scopes of practice, which are detailed in this report.

In its analysis of the scopes of practice for each of the professions, it became clear that some of the challenges facing the health professions, and the health care system more broadly, relate to issues that extend beyond the regulatory framework. HPRAC has identified and addressed a number of structural and process barriers facing the professions including policies, funding and compensation, and historical cultural issues. HPRAC recognizes that there are many facets to health system reform, and that regulatory solutions represent only one element. Our approach in a number of instances is therefore to suggest other steps that need to be taken to address these issues.

Overlapping Scopes of Practice and Shared Controlled Acts

HPRAC reflected on the implications of overlapping scopes of practice for interprofessional collaboration. The RHPA replaced a series of professional monopolies, based on exclusive scopes of practice, with a model of regulation based on controlled acts, most of which are authorized to more than one profession.

Overlapping scopes of practice, and sharing the same or similar controlled acts, represent both an opportunity and a potential barrier to interprofessional collaboration. By making it possible for a number of health professions to initiate and perform many of the same activities, they can enable interprofessional care and increase access to health services. On the other hand, different interpretations of the same or similar controlled acts, different standards of practice and professional practice guidelines employed by professions that perform them, can erect barriers.

These observations led HPRAC to determine that the scope of practice reviews should explore mechanisms for establishing consistent standards among professions for the performance of the same or similar controlled acts.

An Enabling Regulatory Framework

While the RHPA was a momentous step forward in regulating health professions when it was passed in 1991- so much so that other jurisdictions are still trying to emulate the model - it was designed to be living legislation. HPRAC contends that the regulatory framework must constantly change to meet the requirements of the 21st century. HPRAC’s approach, therefore, builds on the principles of the RHPA. It recommends ways to make the regulatory framework more flexible and adaptable, while strengthening the accountability of the regulatory colleges and their members.

The proposed approach allows for the evolution of professional practice over time - consistent with, “changes in practice environments, advances in technology and other emerging issues,” through standards, limitations and conditions adopted by the health regulatory college without recourse to changes in
legislation or regulation. This is balanced with an enhanced role for the regulator to more actively regulate the profession in the public interest and to ensure that an appropriate accountability framework is in place to protect the public from the risk of harm. Specifically, under the enabling model the college will have to address issues of continuing competence and the involvement of other professions in the development of standards, limitations and conditions. HPRAC concluded that the model provides a measured approach with the appropriate checks and balances to protect the public.

A fundamental difference between the proposed approach and the status quo is that the contemplated standards, limitations and conditions, with statutory force, are to be established by the college independent of the regulation-making process. Such a role for the college is consistent with current and future objects under the RHPA.

**Standards of Practice and Professional Practice Guidelines**

**Standards of Practice**

The term “standards” or “standards of practice” is defined differently by various health colleges and other professional entities. For the purposes of this report and specifically in respect of the scope of practice reviews, HPRAC refers to standards of practice as the rules, requirements, responsibilities and conditions that describe the college’s expectations for the profession in Ontario to provide high quality, ethical and safe care to patients. At a minimum, a health profession’s standards of practice should include requirements concerning education, continuing competence, quality assurance, record-keeping, conflict of interest, and mandatory discussion, consultation and transfer of care.

HPRAC’s recommended approach in respect of an expanded scope of practice that authorizes new controlled acts is set out below:

In the profession-specific act:

- provide authority for the performance of new authorized act(s),
- amend the scope of practice statement, if necessary, to address any new authorized act(s),

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14 HPRAC has previously commented on the problems experienced by health regulatory colleges under the RHPA, with the regulation-making process in Ontario. See: HPRAC, Regulation of Health Professions in Ontario: New Directions (April 2006), pp.62-71.
15 See Health Professions Code, s.95, which provides:
“(1) Subject to the approval of the Lieutenant Governor in Council and with prior review of the Minister, the Council may make regulations,

(a) prescribing classes of certificates of registration and imposing terms, conditions and limitations on the certificates of registration of a class; …

(n) prescribing the standards of practice of the profession and prohibiting members from acting beyond the scope of practice of the profession in the course of practicing the profession; …

16 See: RHPA, s.3(1) clauses 3, 4, 7 and 8. Forthcoming changes to the objects of the College, to take effect June 4, 2009, (or some other date established by proclamation) will re-cast these current objects as follows:

4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members. [Replacing the current clause 4.]

8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public. [New.]

9. To promote inter-professional collaboration with other health profession colleges. [New.]

10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues. [New.]
• require members to perform all new authorized acts in accordance with any requirements prescribed in the regulations,
• provide for any other additional requirements for authorized acts that can be pre-determined and are non-exemptible,
• require members to identify the limits of their educational preparation and competencies, and to resolve situations beyond their expertise by consulting with or referring patients to other health care professionals, and
• include a provision enabling Council to make regulations concerning requirements for the performance of new authorized act(s).

In the regulations made under the profession-specific act:

• where appropriate, ensure that members provide satisfactory evidence of successful completion of a post-graduate program that meets approved criteria when they wish to engage in a new authorized act(s),
• require members to perform all new authorized acts in accordance with any standards of practice established by the college from time to time,
• provide for any clarification of authority for the performance of new authorized act(s) as necessary,
• require the college to develop standards of practice for the new authorized act(s) through a process of interprofessional collaboration with other colleges, individuals and entities, and
• require the college to post on its website the standards of practice and, in some cases, those members who are authorized to perform the new authorized act(s).

In following this approach, the standards of practice do not include professional practice guidelines.

Interprofessional Development of Standards, Limitations and Conditions

A key element of HPRAC’s approach is the creation of new, statutory multidisciplinary Professional Standards Committees for each profession. This would allow for a full review, within a profession, of what needs to be included in the standards, limitations, and conditions for controlled acts, and how professions should relate to each other in performing those controlled acts. The framework also provides flexibility to respond to the evolution of professional practice without the constraints of the regulation approval process.

It would establish a permanent multidisciplinary forum to determine the standards, limitations and conditions for the performance of controlled acts that are authorized to a profession. It would involve those health professions who share the same or similar controlled acts, and those who engage in collaborative practice. The current legislative framework imposes no obligation upon colleges to involve representatives of other relevant professions in the development of standards, limitations and conditions. HPRAC is convinced that this is an important step.

Typical of change in any situation, there will be objections to HPRAC’s recommendations. Some will say that it will reduce self-regulation of the professions. Others will say that regulators are too busy managing their own affairs, and should not be called upon to participate in the regulation of other professions. Still others will say that adequate interprofessional relationships already exist.
Chapter 1 – Introduction

HPRAC acknowledges the inherent difficulty in legislating interprofessional collaboration between health professionals, but believes that the proposed model strikes a reasonable balance, requiring the colleges to develop standards, limitations and conditions with input from those with a range of relevant expertise, while at the same time not providing any one with a power of veto. Self-regulation and the obligations of the colleges are respected by placing responsibility for making appointments to the Profession Standards Committee with the colleges.

Professional Practice Guidelines

The regulatory colleges refer to professional practice guidelines in many ways. Some use this term, while others have employed the terms “guidelines”, “clinical practice guidelines” or some other term. Professional practice guidelines set out best practices and procedures for clinical care. For example, in pharmacy practice, a professional practice guideline would set out best practice protocols for minor ailments under a minor ailments program. It is not within HPRAC’s mandate to develop professional practice guidelines. This falls within the mandate, competence and responsibility of the profession.

However, HPRAC will consider whether and what kind of an interprofessional process the professions should follow as they develop professional practice guidelines for authorized acts arising from their scope of practice, particularly where one or more professions share the same or similar authorized act.

HPRAC will engage in consultation and analysis of this issue in the next phase of its work, with recommendations to the Minister to follow in 2009.

Relationship to Non-Physician Authority to Prescribe or Use Drugs

The Minister’s June 2007 letter includes eight separate requests for advice. One of these asked HPRAC to:

examine the authority given to non-physician health professions to prescribe and/or use drugs in the course of their practice under the RHPA [Regulated Health Professions Act, 1991] and the health profession acts.

The Minister also requested HPRAC to:

provide advice specific to each of these professions respecting whether lists, categories or classes of drugs should be prescribed by regulation for the profession, or whether restrictions on prescribing of drugs should be placed in regulation under the respective health profession Act.

Although the prescribing and use of drugs was a key area raised in the scope of practice reviews, HPRAC decided that, while referencing certain of these matters in this phase, it would consider these issues in greater detail when addressing the Minister’s request concerning non-physician professionals who prescribe or use drugs in the course of their practice. Given the complexity of the issues and the implications for patient safety, it is important to consider these questions in a comprehensive, integrated fashion in the parallel project.

HPRAC is aware of the federal government’s proposed regulations for New Classes of Practitioners Regulations, made under the Controlled Drugs and Substance Act. The proposed regulation was pre-

See Request to Implement a Minor Ailments Scheme in Ontario, in the Pharmacy chapter of this report.
Chapter 1 – Introduction

published in the *Canada Gazette, Part I* in June 2007. There was significant interest from stakeholders in response to the proposed regulations, including issues raised by all of the provincial health ministers with respect to implementation and the impact on existing provincial legislation. Health Canada is in the process of working with interested parties to address the concerns raised and is hoping to have the regulation published in the *Canada Gazette, Part II* in late fall.

Health Canada is also in the process of developing a policy framework that will set out criteria and a procedure when considering requests from health professionals for authority to conduct activities with controlled substances within their scopes of practice.

The proposed regulations under the *Controlled Drugs and Substance Act* will impact HPRAC’s work on the project relating to prescribing and use of drugs by health professionals, and will be taken into account as HPRAC formulates its advice to the Minister.

**Balance of Report**

The remaining sections of this report describe scope of practice reviews for the professions of pharmacy, midwifery, dietetics and physiotherapy. HPRAC is confident that the recommendations it is making for each profession will provide them with the flexibility they need, and the rigour that is expected, to be increasingly effective in patient care, and in their work with other professionals.
# Review of the Scope of Practice of Pharmacy

## Index

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPRAC’s Central Response</td>
<td>20</td>
</tr>
<tr>
<td>Background on Pharmacy in Ontario</td>
<td>20</td>
</tr>
<tr>
<td>Pharmacy’s Current Scope of Practice</td>
<td>21</td>
</tr>
<tr>
<td>Community Pharmacy in Ontario</td>
<td>22</td>
</tr>
<tr>
<td>Hospital Pharmacy in Ontario</td>
<td>22</td>
</tr>
<tr>
<td>Views of Practising Pharmacists</td>
<td>23</td>
</tr>
<tr>
<td>What the College and Association Have Proposed</td>
<td>23</td>
</tr>
<tr>
<td>Current Competency Requirements for Pharmacists</td>
<td>27</td>
</tr>
<tr>
<td>Quality Assurance and Continuing Competence</td>
<td>30</td>
</tr>
<tr>
<td>What HPRAC Learned from Research</td>
<td>31</td>
</tr>
<tr>
<td>Perspectives from the Consultations</td>
<td>35</td>
</tr>
<tr>
<td>An Enabling Regulatory Framework</td>
<td>40</td>
</tr>
<tr>
<td>HPRAC’S Observations</td>
<td>44</td>
</tr>
<tr>
<td>HPRAC’s Approach</td>
<td>45</td>
</tr>
<tr>
<td>Medication Therapy Management: What It Includes</td>
<td>45</td>
</tr>
<tr>
<td>Medication Therapy Management in Ontario</td>
<td>47</td>
</tr>
<tr>
<td>A Minor Ailments Program for Ontario</td>
<td>61</td>
</tr>
<tr>
<td>Additional Requests for Initiating Therapy</td>
<td>66</td>
</tr>
<tr>
<td>Scope of Practice Statement</td>
<td>71</td>
</tr>
<tr>
<td>Other Issues Considered</td>
<td>71</td>
</tr>
<tr>
<td>Conclusion</td>
<td>71</td>
</tr>
<tr>
<td>Implementation Proposals</td>
<td>73</td>
</tr>
</tbody>
</table>
Chapter 2 – Review of the Scope of Practice of Pharmacy

Review of the Scope of Practice of Pharmacy

Both the Ontario College of Pharmacists (the College) and the Ontario Pharmacists’ Association (the Association) submitted responses to HPRAC’s questionnaire on the scope of practice review for pharmacy. HPRAC considered the recommendations provided in both submissions.

HPRAC’s Central Response

HPRAC has concluded that pharmacists in Ontario can offer increased, safe and effective patient care to people in Ontario, and contribute more to the management of chronic diseases and interprofessional care. HPRAC is recommending the authorization of additional controlled acts to equip pharmacists with the tools to provide additional services in an expanded scope of practice. HPRAC also recommends that pharmacists should lead a collaborative working group to consider the introduction of a minor ailments program for Ontario.

Background on Pharmacy in Ontario

The College regulates the practice of pharmacy in Ontario. To dispense and sell products defined as drugs, individuals must meet the professional qualifications established by the College and be registered as a pharmacist. Pharmacies must also meet standards of operation and be accredited by the College. In addition to setting the standards of pharmacy practice, the College ensures compliance with professional and operational standards.

The registry of pharmacists has two parts: Part A includes pharmacists who engage in direct patient care and maintain minimum practice requirements; Part B deals with practitioners who do not engage in direct patient care and who are not required to maintain minimum practice requirements. There are 10,343 pharmacists registered under Part A and 675 in Part B for a total of 11,018 active pharmacists in Ontario. Approximately 7,800 practice in community settings while 1,744 work in hospitals. The rest are in academic institutions, government, industry, administration, associations or other professions or are retired or unemployed.

The Association is the professional association representing the views and interests of practicing pharmacists and pharmacists-in-training in Ontario. Membership in the Association is voluntary and currently numbers more than 6,000.

5 http://www.opatoday.com/about.asp
Chapter 2 – Review of the Scope of Practice of Pharmacy

Pharmacy’s Current Scope of Practice

In Ontario, the legislative framework for the health professions includes an umbrella statute, the *Regulated Health Professions Act, 1991 (RHPA)*, and a series of profession-specific Acts that includes the *Pharmacy Act, 1991*. Among other provisions in the *RHPA* is a list of controlled acts, which are health care activities that carry a substantial risk of harm if performed by unqualified people.

Each profession-specific Act includes a scope of practice statement. The scope of practice statement in the *Pharmacy Act, 1991* states:

> The practice of pharmacy is the custody, compounding and dispensing of drugs, the provision of non-prescription drugs, health care aids and devices and the provision of information related to drug use.

The profession-specific Acts also indicate controlled acts, if any, authorized to the profession (authorized acts). The *Pharmacy Act, 1991* gives pharmacists access to specific authorized acts described as follows:

> In the course of engaging in the practice of pharmacy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to dispense, sell or compound a drug or supervise the part of a pharmacy where drugs are kept.

The regulations under the *Drug and Pharmacies Regulation Act* establish three schedules regulating the sale of drugs. Among other conditions, Schedule I drugs can be sold only on prescription; Schedule II drugs, while not requiring a prescription, can be sold only from the dispensary area of a pharmacy; and Schedule III drugs can be sold only from the dispensary or from an area within 10 metres of the dispensary.

Pharmacists work in community retail settings, hospitals, family health teams and long-term care facilities and are recognized as important members of health care teams. Pharmacists provide information to other health care providers about medication therapy – including side effects, drug and drug-food interactions and adverse reactions – and assist prescribers in the appropriate choice of medication for patients. These working relationships include both formal and informal collaborative arrangements. Pharmacists also work directly with patients in managing their medication therapy to ensure compliance. The Association believes that an enhanced scope of pharmacy practice will contribute to interprofessional health care delivery.

The College’s submission to HPRAC states that the scope of pharmacy practice has evolved in recent decades from a prescription-focused model to a patient-centred pharmaceutical care approach. In the 1960s, pharmacists were prohibited by law from putting the name of the drug on the prescription label and were strongly discouraged from speaking to patients about their prescriptions. Today, however, it is an expected standard of practice that pharmacists provide both information and education to their patients.

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9 O. Reg 297/96, *Drug and Pharmacies Regulation Act*


11 Ibid, p. 10.
or agents respecting the use of drugs, health care aids and devices. More recently, other factors have contributed to the evolution of the practice – including the role and regulation of pharmacy technicians, technological advances, the changing needs of an aging population with more emphasis on chronic disease management, and health human resource pressures, such as the shortage of family physicians.

In May 2002, Roy Romanow, who headed the Royal Commission on the Future of Health Care in Canada, told the Canadian Pharmacists Association Conference:

> If pharmaceuticals are a key cost driver in the system, isn’t it simply common sense to make better use of those who are experts in pharmaceuticals? To tap their knowledge, use their skills and bring their expertise to bear in creating a more rational system of drug therapy? Leaving pharmacists on the sidelines is like having Wayne Gretzky on your team – and benching him. It makes no sense and it must change.”

**Community Pharmacy in Ontario**

Currently, community pharmacists in Ontario typically spend 40 percent of their time dispensing medication and 37 percent of their time counselling patients on prescription, non-prescription and special services. Ideally, they would prefer to spend 23 percent of their time dispensing medication and 59 percent of their time counselling patients.

Forty-nine percent of community pharmacists say they personally provide special pharmaceutical care services beyond day-to-day counselling on prescriptions. The most frequent special services are medication management and drug utilization review, diabetes-related care, drug therapy management for seniors, smoking cessation and hypertension management.

More pharmacists would like to collaborate with physicians. Currently, 21 percent of community pharmacists formally collaborate with physicians. Independent community pharmacists are more likely to collaborate with physicians than are mass merchandise pharmacists (32 percent versus 11 percent, respectively).

**Hospital Pharmacy in Ontario**

According to the 2006/2007 Hospital Pharmacy in Canada Report, Ontario hospitals, like those in most provinces, have systems in place for delegating prescribing rights to non-physicians. As of 2006, 66 percent of hospital pharmacists were prescribing drugs. Among this group, dependent prescribing (under some form of delegation) for dosage adjustment was the most common prescribing right, followed by dependent prescribing for a new therapy, independent prescribing for laboratory tests and independent prescribing for dosage adjustment.

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12 Ontario College of Pharmacists. Submission Respecting the Scope of Practice of Pharmacists. p. i.
13 Romanow, Roy. Quoted in Ontario College of Pharmacists. Submission Respecting the Scope of Practice of Pharmacy. p. i.
Chapter 2 – Review of the Scope of Practice of Pharmacy

Views of Practising Pharmacists

Over the past several years the College has examined the role of pharmacy and worked with its members to determine how best to advance the profession’s role in patient care. Much of this consultation took place in the context of discussions on the regulation of pharmacy technicians.

In 2004, the College’s Task Force on Optimizing the Pharmacists’ Role measured pharmacists’ opinions. Pharmacists attending district meetings were asked to complete self-surveys indicating their current knowledge of, and comfort levels with, various roles. Some highlights of the results:

- Being able to conduct medication reviews, monitor chronic therapy and refill medications for chronic therapy were priorities for pharmacists. Close to 70 percent said they were comfortable with conducting medication reviews, and pharmacists were equally split between being comfortable currently versus those saying they needed training before actively monitoring and refilling for chronic therapies. Few said that they will never be comfortable undertaking these practices.
- Three-quarters of pharmacists were comfortable serving as a drug information and advisory resource for physicians.
- Being able to adjust doses for chronic therapy and participating in collaborative practices were relatively high priorities for pharmacists, with 70 percent and 71 percent, respectively, stating that they would need training first. Ten percent of members said they would never be comfortable in these areas.
- More than two-thirds of pharmacists said they were comfortable with participating in trial prescriptions and nearly a third said they would first need training.
- In their individual surveys, pharmacists initially expressed low interest in pursuing independent prescribing and ordering laboratory tests. However, in later breakout groups, pharmacists placed a much higher priority on these areas of practice.

In November 2007, the Association conducted its own informal survey of its membership to determine whether the Association’s vision of the future of the profession aligned with members’ thoughts and expectations. Members were asked questions based on the assumptions that pharmacists would have access to all pertinent patient health information and that they would be trained in administering drugs by injection. In all cases, a majority of respondents said that they either “support” or “strongly support” pharmacists’ ability to partake in the role described. The survey results formed the basis for the nine recommendations included in the Association’s submission to HPRAC.

What the College and Association Have Proposed

The profession is calling for a number of changes in the scope of practice for pharmacists to keep up with the evolution of the practice, align with trends in other jurisdictions, and help solve the challenges facing the health care sector in Ontario. The College says its proposals are intended to:

20 Ibid, p. 2
Chapter 2 – Review of the Scope of Practice of Pharmacy

- reflect current practice, education and competencies of pharmacists,
- increase patient access to timely health services,
- increase efficiencies within the system and enhance cost-effectiveness by decreasing duplication, and
- clarify and enhance pharmacist accountability.\(^{21}\)

As noted, the College and the Association made separate submissions to HPRAC. Following the meetings with each organization, and recognizing that many of the requests in the two submissions were similar, HPRAC requested that the profession provide a list of joint requests as well as a list of any items that were not joint requests.

The joint submission lists ten key recommendations. The Association is seeking three additional changes to the scope of practice. The proposals are discussed in greater depth in the analysis of each request.\(^{22}\)

The joint recommendations are:

1. Provide Schedule II and III drugs as a prescription where required for reimbursement under drug plans.
2. Authorize further extension of a prescription, where there are no existing refills, for continuity of care.
3. Adapt an existing prescription to facilitate patient adherence. These include, changing the dosage form from a capsule or tablet to an oral dosage formulation for patients who have difficulty swallowing; changing the dosage regimen from, say, one tablet twice a day to two tablets once a day to facilitate adherence; changing the dosage form to one reimbursable by the patient’s third party drug benefit plan such as from a capsule to tablet; and when the prescribed dose form or pack size is not commercially available, such as when 50mg only comes in 52.5mg or 30-day pack instead of a 28-day pack, based upon all available information to the pharmacist and the appropriateness for the individual patient.
4. Adjust dosage of existing medication in response to monitoring of laboratory results or other tests.
5. Order relevant laboratory tests for the purpose of monitoring and managing a patient’s medications.
6. Administer a substance by inhalation for the purposes of education and demonstration, with limits and conditions. Administer drugs through injection for patient education and demonstration.
7. Perform a procedure on tissue below the dermis (with limits and conditions).
8. Implement a Minor Ailments Scheme in Ontario similar to the model in Britain. Include Schedule II and III medications.
9. Public Hospitals Act: Permit pharmacists various authorities to treat inpatients, including the recognition of orders for treatment or diagnostic tests given by pharmacists.
10. Health Insurance Act: Allow pharmacists to be classified as “practitioners” under the Health Insurance Act to permit payment for activities within an enhanced scope of practice model. Without this recognition, services and programs funded under the Act may exclude pharmacists due to payment concerns.

There is one fundamental difference in the approach of the two submissions. It concerns the way pharmacists should be authorized to perform the functions listed above. The College recommends that

\(^{21}\) Ontario College of Pharmacists. Submission Respecting the Scope of Practice of Pharmacy. p. i-ii.

\(^{22}\) Additional information for HPRAC, July 31, 2008. Ontario College of Pharmacists and Ontario Pharmacists’ Association. Proposed Wording for HPRAC based on OCP’s and OPA’s Submissions. Document provided to stakeholders in the consultation process.
Chapter 2 – Review of the Scope of Practice of Pharmacy

these be performed through an authorized act of “dispensing without further authorization from a prescriber subject to terms and conditions.” The Association, on the other hand, recommends that these activities be performed under the authorized act of “prescribing.” The issue is addressed as part of HPRAC’s analysis.

In addition to the joint recommendations, the Association proposes to:

- Expand “administering a substance by injection or inhalation for education” to include providing routine injections to patients when it is in the patient’s best interest, appropriate in the pharmacist’s professional judgment, and subject to regulations pertaining to patient privacy and the confidentiality and security of personal health information.
- In addition to Schedule II and III medications in a Minor Ailments Scheme, provide Schedule I drugs for self-limiting conditions; initiate therapy for travel prophylaxis subject to additional training; and initiate therapy for smoking cessation, including Schedule I drugs.

The College has requested a new scope of practice statement as follows:

The practice of pharmacy is the promotion of health, prevention and treatment of diseases, dysfunction and disorders through medication and non-medication therapy; the monitoring and management of medication therapy; the custody, compounding, and dispensing of drugs; the provision of health care aids and devices and information related to their use.\(^{23}\)

Following the meeting with HPRAC, the Association provided comments on the College’s draft scope of practice statement. The Association’s recommendation for a revised scope of practice is:

The practice of pharmacy is the promotion of health, prevention and treatment of diseases, dysfunction and disorders through medication and non-medication therapy; the monitoring and management of medication therapy; the custody, compounding, dispensing and the provision of prescription and non-prescription drugs, health care aids and devices and the provision of information related to their use.\(^{23}\)

The key difference in wording is underlined, and reflects the Association’s different approach to the description of new controlled acts for the profession.

From a regulatory perspective, the joint College and Association submission would require changes to various statutes and regulations:

1. Amendments to the scope of practice statement in section 3 of the *Pharmacy Act, 1991,*
2. Amendments to section 4 of the *Pharmacy Act, 1991* to give pharmacists access to additional authorized acts, based on certain terms, limitations and conditions, including dispensing without further authorization or prescribing; administering a substance by injection or inhalation; and performing a procedure below the dermis, and
3. Access to additional activities\(^{24}\) – based on the revised scope of practice statement and the additional authorized acts – through amendments to other legislation and regulations including the authority to order laboratory tests.

\(^{23}\) Ontario College of Pharmacists. Submission Respecting the Scope of Practice of Pharmacy, p. 4.
\(^{24}\) From “Proposed Wording for HPRAC based on OCP’s and OPA’s Submission”. The OPA recommends that functions hereunder may be performed under the act of “prescribing”. OCP recommends that the functions be performed via by “dispensing without further authorization from a prescriber subject to terms and conditions.”
Rationale for the Proposals

The College said that the proposed changes in scope recognize activities that pharmacists have been doing through delegation, medical directives, the exercise of professional judgment or under section 29(1) of the RHPA (which allows the performance of controlled acts in emergencies and when assisting a person with routine activities of living). The College adds that an expanded scope of practice will enable the profession to fully realize its role in medication therapy management.

Selling, compounding and dispensing a drug includes both technical and cognitive components, and pharmacists are expected to be competent in both areas. Some technical aspects of compounding and dispensing are filled by pharmacy technicians, who will be fully regulated by 2010.

Medication therapy management, on the other hand, encompasses the cognitive aspects of pharmacy – from the role of pharmacists before the decision to dispense a drug, to the monitoring of drug therapy. The College states that medication therapy management reaches far beyond the “counting and pouring, licking and sticking” of traditional pharmacy practice, because it requires pharmacists to gather information from the patient, agent or prescriber to determine whether the prescribed drug is appropriate based on the patient’s medication and relevant history. Pharmacists may also work in partnership with physicians to ensure that the right drug is prescribed at the outset. Furthermore, pharmacists monitor patient compliance and the effectiveness of medication therapy – a key component of medication therapy management.

The College says that pharmacists, often as the first point of access to the health care system, have day-to-day responsibilities that are not adequately reflected in their current scope of practice:

- **Health Promotion and Wellness**: Pharmacists play a relatively important role in health promotion and the prevention and treatment of diseases, dysfunction and disorders through medication and non-medication therapy. Often, in a collaborative arrangement with other health professionals, pharmacists host screening clinics, flu shot clinics and educational days on health promotion and wellness. Many pharmacists also provide screening for cholesterol and diabetes management as well as consultation and information services for other health conditions.

- **Access to Health Care Professionals**: A considerable part of a pharmacist’s practice involves assessing patients and recommending the best options for the treatment of minor ailments, use of non-prescription medications and self-care. Recommendations may include medication or non-medication therapy, lifestyle changes and referrals to other practitioners. Better utilizing pharmacists’ expertise in medication management, including the cognitive components of dispensing and selling drugs, would increase the public’s access to health services for minor ailments, taking pressure off family physicians and emergency rooms.

- **Patient Education**: Counselling patients on the use of prescribed medications, accompanying health care aids and devices and non-prescription therapies is an accepted standard of practice for pharmacy. This regularly entails administering substances through injection or inhalation for educational purposes – for example, to show how to self-inject insulin or use an inhalant device – or pricking the skin to demonstrate the use of glucose monitoring devices. These activities constitute an important component of pharmacists’ role in patient education and medication management.

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• **Professional Judgment:** Pharmacists provide limited refill authority for their patients in some circumstances where they are required to exercise professional judgment – for example, where the patient cannot get a timely appointment with the physician. When it is in the best interests of the patient, pharmacists are increasingly called upon to modify prescriptions, for example, by switching the dosage to facilitate compliance. In 2008, the College and the Association, in collaboration with the College of Physicians and Surgeons of Ontario and the Ontario Medical Association, agreed to conditions under which a pharmacist may authorize and dispense an extension of a prescription for continuing care when the prescribing physician is unavailable to provide refill authorization. A regulatory amendment under the *Drug and Pharmacies Regulation Act* is required to give effect to the Pharmacist Authorization of Prescription Extensions (PAPE) agreement at the point of care.

Similarly, the Association says that pharmacists are considered experts in medication therapy management, based on their rigorous education and training in pharmacology and clinical experience. Pharmacists advise patients on the drugs that have been prescribed, possible adverse effects and allergies and possible interaction with other drugs. As medication usage increases and the population ages, pharmacists often intervene on behalf of the original prescriber to modify or change prescriptions and manage complex medication regimes from multiple prescribers, using their professional judgment.

Pharmacists’ expertise was formally recognized in April 2007 through the MedsCheck program, an initiative of the Ontario government developed in partnership with the Association. Through MedsCheck, pharmacists counsel patients with chronic conditions who are taking three or more medications a day, for 30 minutes once a year. *MedsCheck* was expanded in late 2007 to include follow-up consultations within the year timeframe. As of March 2008, more than 195,000 Ontarians have received a *MedsCheck* and 95 percent of the pharmacies in the province participate. In six months, there were more than 2,600 follow-up consultations, with two-thirds initiated by the pharmacist.

### Current Competency Requirements for Pharmacists

#### Educational Preparation

Pharmacy education in Ontario has evolved from voluntary classes – with no prerequisites – and a predominant emphasis on a long, traditional apprenticeship, controlled by a professional association, to the present compulsory, four-year, second-entry scientific and professional university course with a supervised period of professional practice. Today, registered pharmacy students receive, by the end of their educational preparation, at least a Bachelor of Science in Pharmacy (B.Sc.Phm).

Until January 2008, the University of Toronto Leslie Dan Faculty of Pharmacy was the only pharmacy school in Ontario, offering a Bachelor of Science in Pharmacy, a Master of Science and a Ph.D. in Pharmaceutical Sciences as well as a Doctor of Pharmacy degree (Pharm.D.). The Pharm.D. is a two-year post-baccalaureate program with one year of didactic instruction and one full year of clinical instruction.

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Since 1994, students entering the bachelor’s degree program are required to have a minimum of one year of university course work and also to take the Pharmacy College Admission Test (PCAT) as prerequisites for admission. All four years of the new B.Sc. program emphasize understanding and application of the concept of "pharmaceutical care." The program culminates with a 16-week component of clinical professional practice under the direct supervision of the faculty. As of 2010, University of Toronto will be moving to an entry-level Pharm.D. program, which combines the B.Sc.Phm and the post-baccalaureate Pharm.D.

The University of Waterloo School of Pharmacy is the first new pharmacy school in Canada in 20 years, with its first B.Sc.Phm undergraduate class of 120 students arriving in January 2008. At full operation, the school is expected to have 480 undergraduates, 70 graduate students and 30 faculty members. The School of Pharmacy is offering, for the first time in Canada, a co-operative education program where all students will alternate work terms with academic study throughout the pharmacy program. Similar to the University of Toronto, undergraduate students entering the school are required to have completed a specific set of university level courses. They are not, however, required to take the PCAT. As with the University of Toronto, the Waterloo School of Pharmacy will also be moving toward an entry-level Pharm.D. degree for 2010.

Accreditation

Accreditation is a process for determining whether an educational program produces graduates who meet the required competencies for a regulated scope of practice. The University of Toronto Leslie Dan Faculty of Pharmacy and the University of Waterloo School of Pharmacy are subject to accreditation by the Canadian Council of Accreditation of Pharmacy Programs. The council evaluates the quality of pharmacy professional degree programs in Canadian universities and supports sustained improvement of these programs.

The University of Toronto has full accreditation status for the 2007-2013 period for both the Bachelor of Science in Pharmacy and the Doctor of Pharmacy degree programs. The University of Waterloo received qualifying accreditation status in June 2006 for the School of Pharmacy’s first stage in a new university pharmacy program. Qualifying status confirms that the university’s planning for the pharmacy program has taken into account CCAPP standards and indicates reasonable assurances of moving to the next phase, provisional accreditation. Provisional accreditation signals reasonable assurances that the program will be eligible for full accreditation as experience is gained, generally by the time the first class has graduated.

Entry to Practice

There are three levels of registration with the College: registered pharmacy student, intern and registered pharmacist. To attain full registration as a pharmacist in Ontario, four steps must be completed:

- Pre-register with the College before obtaining any level of registration.

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32 University of Waterloo. School of Pharmacy. About the School of Pharmacy. Accessed August 5th, 2008.
33 More information is available through the CCAPP website: www.ccapp-accredit.ca
34 For the full accreditation policy, see CCAPP. http://www.ccapp-accredit.ca/accredited_programs/accreditation_decision.php
• **Register as a student.** Registered students have privileges outlined in the *Pharmacy Act, 1991*, and work or volunteer as pharmacy students in addition to completing clinical rotations as part of an accredited pharmacy degree.

• **Register as an intern.** The internship is the training period that provides transition from working under direct supervision to working independently as a pharmacist. An intern has completed studentship training, either through an undergraduate program or through the College’s Structured Practical Training.

• **Register as a pharmacist.** After completing the internship, the Jurisprudence Examination and the Pharmacy Examining Board of Canada (PEBC) Qualifying Examination Parts I & II, applicants are eligible to apply for a Certificate of Registration as a Pharmacist.

To be a registered pharmacist in Ontario, an individual, among other conditions, must:\n
• Have an undergraduate pharmacy degree recognized by the PEBC,
• Have a Certificate of Qualification from the PEBC,
• Pass the College's Pharmaceutical Jurisprudence examination, and
• Successfully complete in-service training while registered as a student and/or intern with the College.

In-service training for registration as a pharmacist may be completed only while a candidate is a registered student or an intern. Some components, for example, passing the Pharmaceutical Jurisprudence examination or the PEBC Qualifying Examination, may be completed prior to or during internship.

**Examinations**

As indicated above, in addition to meeting education requirements, pharmacists must complete two examinations before they are eligible for registration with the College.

• The Pharmaceutical Jurisprudence examination\(^{37}\) is based on the College’s standards and policies and federal and provincial laws and regulations that control the production, distribution, advertising, sale and use of drugs.

• PEBC\(^{38}\) is the national certification body for the pharmacy profession in Canada. The PEBC assesses entry to practice qualifications for pharmacists acceptable to participating licensing bodies by awarding Certificates of Qualification to applicants who pass a qualifying examination. PEBC assesses the qualifications of both Canadian and international graduates.

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\(^{35}\) Structured Practical Training SPT is the student and intern in-service training requirement for registration as a pharmacist in Ontario, completed under the supervision of a qualified preceptor. Students and interns complete activities relevant to their practice site and self-assessments of their performance as they proceed through the training period. Additionally, the preceptor completes written assessments of the student or intern’s performance. The assessment process documents the student or intern’s progress as well as highlights specific areas for improvement.


The qualifying examination evaluates an applicant’s competence – knowledge, skills and abilities – to practise pharmacy safely and effectively in an entry level position. This evaluation is based on the model practice competencies defined in Professional Competencies for Canadian Pharmacists at Entry to Practice by the National Association of Pharmacy Regulatory Authorities, 1997, updated in 2007. The qualifying examination ensures that successful candidates have met the required standard of competence.  

**Quality Assurance and Continuing Competence**

**Quality Assurance**

Pharmacists are required to opt into Part A or Part B of the College’s register. Part A includes pharmacists who engage in direct patient care and maintain the minimum practice requirements. All pharmacists in Part A are subject to random selection for the College’s Quality Assurance Practice Review. Part B of the register lists pharmacy practitioners who do not engage in direct patient care; they are not required to maintain minimum practice requirements and are not subject to the Quality Assurance Practice Review process.

The Quality Assurance Practice Review consists of two phases:

- Every year, 20 percent of members in Part A of the register are selected to take part in Phase I. As a result, every pharmacist in Part A will be selected to participate in Phase I once every five years. Those selected are required to complete the Self-Assessment Survey and Summary of Continuing Education Activities and submit them to the College within eight weeks.
- Approximately 240 pharmacists a year are selected for Phase II, known as Peer Review. This is a clinical knowledge and practice-based assessment lasting approximately six hours. Peer Reviews are held quarterly in Toronto at the College offices. The Phase II assessment is based on the national model competency document developed by the National Association of Pharmacy Regulatory Authorities. Members who fall short of standards can be required to take education programs and be reassessed. Members have the right to make written or oral submissions to the Quality Assurance Committee following the receipt of their report and the Committee’s decision.

**Continuing Education**

Although continuing education programs are not mandatory, pharmacists are expected to maintain competency through professional development activities to provide optimal patient care.
To assist pharmacists with their professional development, the College offers a number of tools. The Self-Assessment Survey helps members identify strengths and learning needs and the Learning Portfolio helps members develop learning goals and education action plans and document learning activities.

The College also provides continuing education resources including lists of conference and events, specialty and certificate courses, online learning, continuing education providers, clinical resources and textbook references. Similarly, the Association develops and maintains education programs in line with members’ needs. The Association provides in-person and web-based certificate and credentialing programs, among other professional education tools. 44

**What HPRAC Learned from Research**

In addition to reviewing background information and the detailed submissions received from the College and the Association, HPRAC undertook a review of the published literature, a jurisdictional review of the scope of practice of pharmacists outside Ontario, and a jurisprudence review of the scope of practice of pharmacists nationally. The literature and jurisdictional reviews were posted on HPRAC’s website.

**Literature Review**

The literature review focused on identifying key documents to help inform HPRAC’s analysis.

Initial reference documents were included in the submissions to HPRAC by the College and the Association. 45 Additional sources were found through the use of search engines such as PubMedline Search. As well, follow-up efforts were made to locate specific items from government websites, pharmacy associations and health policy think tanks.

The research showed that there is little literature available specifically on the issue of the scope of practice for pharmacy. Most of the evidence that is available on the benefits of an enhanced or expanded scope of practice, especially with regard to pharmacist prescribing, is anecdotal and based on a few randomized studies.

**System Needs**

Multidisciplinary collaborative pharmacy care has been identified as a means of sustaining and improving access to and quality of pharmacy care. 46 Pharmacy scope of practice reviews and reforms are being driven by international trends and health system changes related to primary health care reform, interprofessional team-based care, effective utilization of health human resources and the need to improve safety outcomes of drug therapy. The literature points to some requirements for an effective collaborative prescribing model, including: a collaborative practice environment; a shifting of workload (utilization of pharmacy technicians); access to patients; access to medical records; knowledge, skills and ability; documentation of activities; compensation for activities; and changes to legislation and practice models. 47

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46 See, for example, Pearson, Glen J. et al. An Information Paper on Pharmacist Prescribing Within a Health Care Facility.
47 See, for example, Pearson, Glen J. et al. An Information Paper on Pharmacist Prescribing Within a Health Care Facility.
A 1998 literature review summarizing pharmacists’ potential impact on health care\(^\text{48}\) said that intervention of pharmacists on behalf of patients to improve their drug therapy and provide enhanced pharmaceutical care can influence health system results – such as incidence of drug reactions, hospital length of stay, disease control, cost of drugs, professional time and general utilization of health services. Although the review concluded that larger, controlled studies with measurable results were needed, it also confirmed that some evidence is beginning to emerge in support of the role pharmacists can play in improving the performance of the health care system.

Some literature describes the implications of expanded roles being played by pharmacists in drug therapy in specific jurisdictions.\(^\text{49}\) Most studies focused on pharmacists’ perceptions of supplementary prescribing\(^\text{50}\) and other enhanced roles – such as diagnosing or communicating a diagnosis and administering a substance or drug by injection or inhalation – with little information referring to other stakeholders.\(^\text{51}\)

Scope of Practice

Barriers to enhanced pharmacy roles have been identified including: the evolution of the profession, scope of practice, regulatory issues of overlap and shared practice, medico-legal and liability concerns, education and training, and lack of awareness.\(^\text{52}\) However, emerging anecdotal evidence supports the potential for an enhanced scope of practice for pharmacists. This is designed to bring about positive change in patients’ health as a result of improvements in the continuity of patient care and models of care delivery.\(^\text{53}\)

Many jurisdictions across Canada and around the world permit pharmacists to fully engage in the activities required to optimize medication therapy management. The extent and type of pharmacist prescribing and other enhanced roles is influenced by a number of factors – including the motivation of pharmacists to expand their scope of practice, physicians’ reactions to pharmacists’ enhanced roles, the influence of health care work environments, acceptance by third party payers, reimbursement for professional services and, significantly, the public’s acceptance and demand for pharmacists to prescribe.\(^\text{54}\) In particular, Alberta’s newly expanded scope of practice\(^\text{55}\) for pharmacists is considered a


\(^{50}\) Supplementary prescribing, as introduced in Britain, allows a pharmacist to prescribe according to the patient’s specific clinical management plan. See Cooper et al. (2008) *Nurse and Pharmacist Supplementary Prescribing in the UK – A Thematic Review of the Literature*. *Health Policy* 85 277-292.


\(^{54}\) See Bacovsky, RA. *Pharmacists Prescribing in Alberta: An Examination of the Literature and Pharmacist Practices*.

\(^{55}\) See, for example: Bacovsky RA. Prescribing Pharmacists in Alberta: Understanding the Conditions and Implications of Their Expanded Role in Drug Therapy; Pearson, Glen J. *Evolution in the practice of pharmacy – not a revolution!*
potential model for other Canadian jurisdictions and is expected to result in improved health outcomes by optimizing drug therapy for patients.

The limited research available suggests pharmacists are perceived as being more positive about supplementary prescribing, with physicians being more critical, largely due to lack of awareness and understanding of the arrangement. The evaluation of pharmacist prescribing varies with the practice environment. The evolution and success of the prescribing role depends on health system design, acceptance by the public, acceptance by physicians, methods of reimbursement and acceptance by pharmacists themselves.

Patient Safety and Outcomes

A body of evidence is emerging on the recent introduction of independent prescribing and other enhanced roles – including collaborative models of prescribing, supplementary prescribing and medication therapy management. This literature is largely focused on perceptions about reforms being implemented in Alberta and in Britain. Reforms unfolding in those jurisdictions are expected to generate substantial research on these issues.

More research is needed on the effectiveness, quality and value of building on the strengths and scope of practice of pharmacy to enhance patient care. For example, practical implementation issues related to enhanced roles require exploration, and the impact and outcomes of specific changes currently being implemented in some jurisdictions should be assessed.

The literature identified several issues that call for further investigation, including: a comprehensive self-analysis of current pharmacy practice; consideration of the goals and objectives of prescribing; a negotiation of provincial and national health policy guidelines; training and accreditation; liability, reimbursement and documentation; an assessment of the impact of supplementary prescribing and other reforms on safety; economic analyses; patients' experiences; and finally, the development of a rigorous clinical governance framework to assess the relative merits of establishing different types of prescribing models in different settings.

Jurisdictional Review

To gain a better understanding of where Ontario stands in relation to other Canadian provinces and key international centres, HPRAC undertook a jurisdictional review.

56 See Cooper et al. Nurse and Pharmacist Supplementary Prescribing in the UK – A Thematic Review of the Literature.
Canadian Scope of Practice Statements

The prevailing scope of practice for pharmacists in Canada, as expressed in the legislated scope of practice statements, includes the custody, compounding, packaging and repackaging, labelling, dispensing and selling of drugs and other health related products. Some jurisdictions include additional roles in their scope of practice statements, such as:

- Disseminate information on the safe and effective use of a drug or other relevant information (British Columbia, Alberta, Manitoba, New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island, Québec, Northwest Territories and Nunavut);
- Monitor the drug therapy provided to patients (British Columbia, Alberta, New Brunswick, Northwest Territories and Nunavut);
- Supervise and manage drug distribution systems (Alberta and New Brunswick);
- Interpret and evaluate prescriptions (British Columbia); and
- Provide blood products and parenteral nutrition (Alberta and New Brunswick).

Authorized Acts in Canada

All provinces and territories authorize licensed pharmacists to sell, store, and dispose of drugs, both prescription and non-prescription, in a manner specified in the relevant legislation and drug schedules. Most authorize pharmacists to interchange a drug product with another brand or a generic drug unless the person prescribing the drug indicates otherwise in a manner specified in the relevant legislation (British Columbia, Saskatchewan, Manitoba, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, Northwest Territories and Nunavut). Further, some jurisdictions allow pharmacists to modify prescriptions (Alberta, Northwest Territories and Nunavut). As well, some authorize pharmacists to renew or dispense a drug contrary to the terms of prescription under limited circumstances (British Columbia, Northwest Territories and Nunavut) or to prescribe drugs for emergency contraception (British Columbia, Québec and Saskatchewan).

Nova Scotia provides for conditional authority agreements between the College of Pharmacy and the College of Physicians and Surgeons. These agreements authorize a specific pharmacist to carry out certain medical activities, services or functions (including the authority to prescribe Schedule I drugs under limited circumstances). Furthermore, in Québec, pharmacists are authorized to issue a pharmaceutical opinion, as well as to initiate or adjust medication therapy according to a prescription, making use of laboratory analysis when necessary.

Innovations in Alberta

Pharmacy has a broader scope of practice in Alberta, where pharmacists are permitted to administer a vaccine or parenteral nutrition, compound blood products, and insert or remove instruments, devices or fingers beyond the anal verge and beyond the labia majora, for example, for the administration of suppositories.

Pharmacists may prescribe a Schedule 1 drug and blood products for the purpose of adapting an existing prescription if it is not possible for the patient to see a health professional and there is an immediate need for the drug or blood product. Pharmacists who meet further registration requirements can receive additional prescribing authorization. This enables them to prescribe Schedule I drugs and blood

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products to treat minor disease conditions or to manage drug therapy.61 Alberta pharmacists may also, under certain circumstances, administer subcutaneous or intramuscular injections.

Anticipated Canadian Legislative Reforms

Several provinces anticipate legislative reforms that will afford pharmacists greater access to authorized acts and broaden their scope of practice (British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia and Saskatchewan). The most imminent changes will take place in New Brunswick, where significant amending legislation comes into force in October 2008, and in Manitoba, where amending legislation is awaiting proclamation.

Selected Foreign Jurisdictions

In addition to standard pharmaceutical practice, pharmacists in Britain may obtain prescribing authority as either supplementary or independent prescribers. Supplementary prescribers act in partnership with physicians or dentists to implement an agreed patient-specific clinical management plan. Independent prescribers are solely responsible for the assessment and clinical management – including the prescribing of drugs – of patients with undiagnosed or diagnosed conditions.

As well, a number of communities in Britain have minor ailments schemes in place, regulated by the Pharmaceutical Society. In general, these schemes permit pharmacists to advise patients suffering from minor ailments and provide drug therapy from a formulary of allowable products.

In Queensland, Australia, in addition to standard pharmaceutical practice, pharmacists are explicitly authorized to: substitute brands for generic products, provide directly supervised opioid substitution treatment, ensure that cytotoxic drug products are prepared and handled properly, provide smoking cessation services, provide a needle and syringe program and promote safer practices to injecting drug users, and provide a monitoring and case detection service that involves testing, explaining results, documentation and appropriate follow-up and referral, with the aim of optimising health and quality of life.

Perspectives from the Consultations

HPRAC’s consultation program was designed to gain additional information, perspectives and understanding of issues, benefits and risks linked with changing the scope of practice of pharmacists in Ontario. As part of the consultations, HPRAC held broad local health provider roundtables in five communities, met with other regulators and professional associations and conducted a number of key informant interviews. A separate meeting was also arranged with pharmacy educators.

HPRAC received more than 85 written responses to the review of the scope of practice for pharmacy. A number of letters of support were submitted by individual pharmacists, pharmacies in both community and hospital settings and other pharmacy organizations and associations. In addition, HPRAC received

61 Pharmacists Profession Regulation, AR 129/2006 Section16(3) Subject to subsection (4), a clinical pharmacist is authorized to perform, within the practice of pharmacy and in accordance with the Pharmacists’ Standards of Practice, the restricted activities of prescribing a Schedule I drug and prescribing blood products if the clinical pharmacist:

(a) has provided evidence satisfactory to the Registrar of having successfully completed the Council requirements to prescribe Schedule I drugs and blood products, and

(b) has received notification from the Registrar that the authorization is indicated on the clinical register.
submissions from other health care providers and organizations. Some indicated their support, others raised issues and concerns, and some did both. HPRAC has considered these responses in its analysis and recommendations. All of the responses are available on HPRAC’s website.

**Interprofessional Consultation**

In developing its submission to HPRAC, the College held a consultation session on the Pharmacists Scope of Practice Review in May 2008. Representatives from the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the Royal College of Dental Surgeons of Ontario, the Ontario College of Family Physicians, the Ontario Dental Association, the Ontario Medical Association, the Nurse Practitioners Association and the Registered Nurses Association of Ontario attended. The College reports that participants expressed support for the greater use of the expertise of pharmacists in medication management, especially in collaboration with other professions. However, there was no consensus on whether pharmacists should be granted the authority to perform additional authorized acts or if pharmacists should continue performing the controlled acts under delegation, medical directives, section 29(1) of the *RHPA*, and professional judgment.\(^\text{62}\)

**Input from the Roundtables**

The key points emerging from HPRAC’s roundtable consultations on the pharmacy scope of practice referral are summarized under three main categories: System Needs, Scope of Practice and Competency.

At each roundtable, a representative from the College and the Association provided a brief introductory presentation outlining the request made by the profession in response to the Minister’s request for advice.

**System Needs**

One of the consistent themes from comments by both hospital and community pharmacists was that much has changed over the last 15 years since the introduction of the *RHPA*, in both how pharmacy is practised and how pharmacists are educated. Most participants commented on how the practice now is much more collaborative and said this is a very positive development.

Many participants said that patient care would be more effective if the recommendations made by the College were implemented. Some of the main issues noted were medication therapy management, the treatment of what are called minor ailments and the authority to refill prescriptions.

Many pharmacists described day-to-day issues that place barriers in the way of more effective patient care, observing that outdated rules and practices were denying timely and efficient access to care. Access was seen overall as the most serious health system issue. It was noted that access to a family physician is limited or non-existent in many areas of the province. Other health care professionals, such as pharmacists, can play a bigger role in patient care. Examples were provided where pharmacists had to spend too much time trying to contact a patient’s physician when the pharmacist could have provided the appropriate advice much sooner. Specific issues included:

- too much time spent on unnecessary medical directives;
- unnecessary wait times for prescription refills;
- too much time spent on paperwork and “working around” barriers.

\(^\text{62}\) Ontario College of Pharmacists. Submission Respecting the Scope of Practice of Pharmacists. p.22.
One of the issues the pharmacists underlined was the increasing need for home care and long-term care and the pharmacist’s expanding role in long-term care homes. Representatives from Local Health Integration Networks, Continuing Care Access Centres and long-term care homes all stated that having greater access to pharmacists with an expanded scope would promote the more timely delivery of health care to both long-term care residents and those requiring home care.

Finally, physicians, nurse practitioners and other health care professionals expressed their confidence in the expertise and reliance on the pharmacist as part of the patient’s circle of care. Many participants in the roundtables indicated that by utilizing the pharmacist resource, their own time is freed for other aspects of patient care, and they are able to rely on a professional with greater expertise than their own in pharmacology and medication management.

**WHAT HPRAC HEARD ABOUT…SYSTEM NEEDS**

“Where my time gets wasted, and the physician’s time gets wasted, are when I am monitoring a patient and need lab values and can’t order them; if the patient needs a 5 mg. tablet instead of a 4 mg. tablet, I can’t prescribe it; or if the patient needs to see a social worker or a dietitian, I can’t refer them. All of these must go back to the family doctor, who I have to find and interrupt. That is the reality of life in a family health team.”

Sherri Elms, Pharmacist, Queen’s Family Health Team Kingston, Ontario

“The suggestions for minor ailments that can be addressed by a pharmacist will certainly take a lot of pressure off walk-in clinics for people without a family physician, and may take pressure off family physicians. If you consider an antiviral for treating people with shingles in that important 72 hour window of time, it makes a big difference to the patient since a lot of people won’t be able to see a doctor within that time, and you don’t want them all in a hospital’s emergency ward.”

Janet McCutchon, Pharmacist, Co-owner, Community Pharmacy Thunder Bay, Ontario

“When a person runs out of medication, the pharmacist can either direct the person to a walk-in clinic or the emergency department at the hospital, where there is no record of the patient’s health or clinical history. Or the pharmacist, who knows the history, could deal with it. This happens about ten, 15 or 20 times every day.”

Ken Burns, Pharmacist, Sudbury, Ontario; Chair, Ontario Pharmacists’ Association

**Scope of Practice**

The pharmacist participants at the roundtables made clear that they were not suggesting that they should replace the role of family physicians; nor did they want to carry out procedures for which they were not trained. They saw the expanded scope as both reflecting their current level of education and training and in helping the health care system be more timely and effective.
Chapter 2 – Review of the Scope of Practice of Pharmacy

The key point often raised in the discussions was the use of medication therapy management. This involves knowing which drugs require monitoring through laboratory tests and subsequent dosage adjustment depending on the test results. Pharmacists are playing a greater role in educating patients in the use of insulin injection, glucose monitoring, and inhalation devices. In their view, these activities need to be more clearly recognized in their scope of practice and in appropriate authorization for specific controlled acts.

**WHAT HPRAC HEARD ABOUT…SCOPE OF PRACTICE**

“For a hospital pharmacist, there is a broader scope of practice as we are able to practice in a more collaborative sense within a health care team. This is partly from direct physician and patient interaction, and access to other members of the health care team. In the hospital, under medical directives, we are able to offer pharmacist-driven clinical interventions including renal dosage adjustments, a warfarin dosing service, pharmacokinetic monitoring and automatic therapeutic interchanges (autosubstitutions) that help to modify dosages of high risk medications. Adjusting total parenteral nutrition for electrolyte changes after monitoring a patient’s clinical condition, and supervising TPN preparation falls under a high risk practice of compounding, that is in the scope of a hospital pharmacist.”

Christine Donaldson, Hotel Dieu Grace Hospital, Regional Director of Pharmacy
Windsor, Ontario

“Out of the Auditor General’s review, we have established a joint committee with the Ministry of Health and Long-Term Care and the Institute for Safe Medication Practices of Canada. [With the changes proposed] there will be opportunities to enhance the pharmacist’s role in medication management within long-term care.

When a resident comes into long-term care, new medication orders are needed. It would be good if a pharmacist could actually initiate the medications based on previous orders. This would provide continuity of care until the physician comes in to assess the resident and write new orders.

The electronic health record is a key element in this process to enable interprofessional collaboration.”

Nancy Cooper, Director of Policy and Professional Development
Ontario Long-Term Care Association

It was often pointed out that these expanded activities would not be done in isolation but rather in a collaborative framework, whether in the community, in a hospital, or within a family health team. Most participants commented on the need for the establishment of more effective electronic health records that could be shared throughout the health care system. While important improvements are coming to the way in which individual pharmacies will be able to communicate with each other, much more needs to be done.

Overall, roundtable participants supported the pharmacists’ request but strongly emphasized the need for enhanced interprofessional collaboration, communication and information sharing in a timely manner.
WHAT HPRAC HEARD ABOUT…COLLABORATION

“We collaborate with physicians and other health care professionals such as dietitians, nurse practitioners, nurses, and mental health workers – everything is done as a team. For instance, in the diabetes clinic, the physician sees patients quarterly to perform regular monitoring. In some of the offices, the physician performs the visits in collaboration with a pharmacist, a nurse practitioner or a dietitian. We often have the same training as far as many clinicians are certified diabetes educators. This insures more consistency with the delivery of messages to the patient.”

Antony Gagnon, Pharmacist, Pharmacy Program Manager, Hamilton Family Health Team
Hamilton, Ontario

“It is not optimal care for emergency physicians to be writing prescriptions for ongoing chronic medication. If we can maintain chronic medication in a facility such as a long-term care home, where the physician can reassess at intervals, that would be good collaborative care for people who need it.”

Lynn Halliday, Pharmacist, Espanola Family Health Team
Espanola, Ontario

“A lot of people say that scopes of practice are expanding because we have a shortage of health professionals. I would say that the scopes are expanding because the complexity of care has become so great over the last 25 years. The number of drugs on the market has exploded. No one person can know what a family physician knows, what a pharmacist knows, what a dietitian knows, what a physiotherapist knows. We have to work together to care for patients.”

Sherri Elms, Pharmacist, Queen’s Family Health Team
Kingston, Ontario

Competency

One of the key questions raised was whether pharmacists today have the necessary educational preparation to carry out the proposed changes in scope of practice. In addition to the roundtables, HPRAC examined this issue with key educators from the University of Toronto and the University of Waterloo. It was noted that all pharmacists educated since the mid-1990s have the required competencies to meet the proposed changes in scope, and that instructional programs are continuously upgraded to meet evolving practice needs. In the field, pharmacists commented that both through their undergraduate and postgraduate training, and then through focused continuing education programs they were able to maintain a high level of professional competency.

The pharmacist participants conveyed a clear sense that the College plays a very strong role in ensuring that the profession’s educational standards are met on a sustained basis. Finally, in the roundtable with other colleges and associations having a close relationship to pharmacy, general agreement was expressed that pharmacists have the competency to carry out the proposed responsibilities.
WHAT HPRAC HEARD ABOUT…COMPETENCY

“This is an academic Family Health Team, and therefore its mission is to train future primary care providers, including family medicine residents. Within our offices, the volume of written communications from community pharmacists on things like dosage forms that don't exist, ointment or cream etc. is substantial. This is one of the huge sources of frustration for the residents. They ask me, “Why is someone bothering me about this? Why is someone contacting me with this and delaying the patient's treatment?” But unfortunately that is the way the law is…and it unfortunately affects the way future physicians perceive the profession of pharmacy and what pharmacists can contribute.”

Lisa McCarthy, Assistant Professor, Leslie Dan Faculty of Pharmacy, University of Toronto and Assistant Clinical Professor, Family Medicine, McMaster University

“Assessing, initiating and monitoring the most appropriate therapy for smoking cessation, whether it be a Schedule 1 drug or an unscheduled product, and working with the patients to help them succeed is very important.”

David Malian, Community Pharmacist, Windsor, Ontario

An Enabling Regulatory Framework

While the RHPA was a momentous step forward in regulating health professions when it was passed in 1991 – so much so that other jurisdictions are still trying to emulate the model – it was designed to be “living legislation”. HPRAC considers that the regulatory framework must continue to meet the changing needs of the 21st Century.

HPRAC is therefore proposing a new approach to the regulation of pharmacy: an enabling regulatory framework. This approach builds on the principles of the RHPA. It recommends ways to make the regulatory framework more flexible and adaptable, while strengthening the accountability of the regulatory colleges and their members.

An enabling regulatory framework couples a broader professional scope of practice in legislation and regulations with appropriate standards, limitations and conditions to be established by the regulatory college for the performance of authorized acts. The standards of practice would be recognized in the statute, giving the College the clear legal authority to mandate compliance by members. The College would be required to involve other professions in the development of these standards, nurturing interprofessional collaboration.

The proposed approach allows for the evolution of pharmacy practice over time – consistent with “changes in practice environments, advances in technology and other emerging issues” – through standards, limitations and conditions adopted by the College without recourse to changes in legislation or regulation. This direction is balanced with an enhanced role for the regulator (the College) to more actively regulate the profession in the public interest and to ensure that an appropriate accountability

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63 HPRAC has previously commented on the problems experienced by health regulatory colleges under the RHPA, with the regulation-making process in Ontario. See: HPRAC, Regulation of Health Professions in Ontario: New Directions (April 2006), pp.62-71.
framework is in place to protect the public from the risk of harm. Specifically, under the enabling model, the College will need to address issues of continuing competence and the involvement of other professions in the development of these standards, limitations and conditions. HPRAC concluded that the model provides a measured approach with the appropriate checks and balances to protect the public.

A fundamental difference between the proposed approach and the status quo is that the contemplated standards, limitations and conditions, with statutory force, are to be established by the College independent of the regulation-making process. Such a role for the College is consistent with its current and future objects under the RHPA.53

This approach is also consistent with the evolution of health professions in Ontario since the enactment of the RHPA and the emerging issue of advanced practice in many of the health professions. As such, it provides for a new way of doing business that will be applicable to other health professions and their respective regulatory colleges.

Both the College and the Association recognize the need to place standards, limitations and conditions on much of what is being proposed to ensure that patients receive the best care, and that other practitioners who share in a patient’s care are fully informed.

The evolving model for regulating pharmacists in Ontario will require a period of transition to enable the College to put the necessary policies in place and to establish the necessary detailed standards, limitations and conditions, in consultation with the other relevant regulatory colleges and members of other regulated health professions.

Interprofessional Collaboration and the Development of Standards of Practice and Professional Practice Guidelines

The Minister has requested HPRAC to:

recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession.

64 See Health Professions Procedural Code, s.95, which provides:
“(1) Subject to the approval of the Lieutenant Governor in Council and with prior review of the Minister, the Council may make regulations,
(a) prescribing classes of certificates of registration and imposing terms, conditions and limitations on the certificates of registration of a class; …
(n) prescribing the standards of practice of the profession and prohibiting members from acting beyond the scope of practice of the profession in the course of practicing the profession; …

65 See: RHPA, s.3(1) clauses 3, 4, 7 and 8. Forthcoming changes to the objects of the College, to take effect June 4, 2009 (or some other date established by proclamation) will re-cast these current objects as follows:
4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members. [Replacing the current clause 4.]
8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public. [New.]
9. To promote inter-professional collaboration with other health profession colleges. [New.]
10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues. [New.]
The Minister has also asked HPRAC to:

- take into account, when controlled acts are shared, of public expectations for high quality services no matter which health profession is responsible for delivering care or treatment.

**Standards of Practice**

The term “standards” or “standards of practice” is defined differently by various regulatory colleges and other professional entities. For the purposes of this report and specifically the scope of practice reviews, HPRAC refers to “standards of practice” as the rules, requirements, responsibilities and conditions that describe the College’s expectations for pharmacists in Ontario to provide high quality, ethical and safe care to patients in respect of an expanded scope of practice. At a minimum, a health profession’s standards of practice should include requirements concerning education, continuing competence, quality assurance, record-keeping, conflict of interest, and mandatory discussion, consultation and transfer of care.

HPRAC’s recommended approach in respect of an expanded scope of practice for pharmacy is set out below:

In the *Pharmacy Act, 1991*:

- provide authority for the performance of new authorized act(s),
- amend the scope of practice statement, as necessary, to address the parameters of the new authorized act(s),
- require members to perform all new authorized acts in accordance with any requirements prescribed in the regulations,
- provide for any other additional requirements for authorized acts that can be pre-determined and are non-exemptible,
- require members to identify the limits of their educational preparation and competencies, and to resolve situations beyond their expertise by consulting with or referring patients to other health care professionals, and
- include a provision enabling the College’s Council to make regulations concerning requirements for the performance of new authorized act(s).

In the regulations made under the *Pharmacy Act, 1991*:

- where appropriate, ensure that members provide satisfactory evidence of successful completion of a post-graduate program that meets approved criteria when they wish to engage in a new authorized act(s),
- require members to perform all new authorized acts in accordance with any standards of practice established by the College from time to time,
- provide for any clarification of authority for the performance of new authorized act(s) as necessary,
- require the College to develop standards of practice for the new authorized act(s) through a process of interprofessional collaboration with other regulatory colleges, individuals and entities, and
- require the College to post on its website the standards of practice and, in some cases, those members who are authorized to perform the authorized act(s).
In following this approach, the standards of practice do not and would not include professional practice guidelines.

Interprofessional Development of Standards, Limitations and Conditions

A key element of HPRAC’s approach is the creation of a new Pharmacy Standards Committee. This step would allow for full review and consultation on the matters to be included in the standards, limitations, and conditions, while providing flexibility to respond to the evolution of pharmacy practice, as these matters would not have to be addressed in regulation.

The rationale for this proposed change is to establish a permanent forum where legitimate concerns about the standards, limitations and conditions for pharmacists’ performance of controlled acts can be meaningfully discussed and resolved among the health professions that will be engaged in collaborative practice with pharmacists. The current legislative framework imposes no obligation upon a college to involve representatives of other relevant professions in the development of standards, limitations and conditions.

HPRAC acknowledges the inherent difficulty in legislating interprofessional collaboration among health professionals, but is convinced that the proposed model strikes a reasonable balance – requiring the College to develop standards, limitations and conditions with ongoing input from persons with a range of relevant expertise, while at the same time not providing any one participant in the process with a power of veto. The self-regulatory role and responsibilities of the College are respected by placing responsibility for making appointments to the Pharmacy Standards Committee with the College. The majority of the committee would be pharmacists. HPRAC is further recommending that there be representation from the pharmacy education community.

Professional Practice Guidelines

The regulatory colleges refer to professional practice guidelines in many ways. Some use this term, while others have employed the terms “guidelines”, “clinical practice guidelines” or some other phrase. Professional practice guidelines set out best practices and procedures for clinical care. As an example, in pharmacy practice, a professional practice guideline would set out best practice protocols for treatment of minor ailments under a minor ailments program.  

It is not within HPRAC’s mandate to develop professional practice guidelines. This falls within the mandate, the competence and indeed the responsibility of the profession.

What HPRAC proposes to do, however, is to consider whether and what kind of an interprofessional process should be followed by the professions themselves as they develop professional practice guidelines for authorized acts arising from their scope of practice, particularly where one or more professions share the same or similar authorized act.

HPRAC will engage in consultation and analysis of this issue as the second phase of its interprofessional collaboration project continues, with recommendations to the Minister to follow in 2009.

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66 See Request to Implement a Minor Ailments Scheme in Ontario, below.
HPRAC’S Observations

HPRAC received separate submissions from the College and the Association, and has relied on much of the information and references contained in each of those submissions. For the purpose of its analysis of each of the recommendations for changes to the scope of practice, HPRAC has relied on the joint document prepared by the Association and the College following its initial meetings. HPRAC has further grouped the various requests for the purposes of analysis and recommendations.

In addition to the information and references provided by the College and the Association in their submissions, the following analysis builds on the information gathered and reported in the literature review, the jurisdictional review, the written responses submitted to HPRAC and the consultations. The analysis is based on consideration of HPRAC’s criteria for reviewing a scope of practice.

The issues identified by the College and the Association reflect an evolution in pharmacy’s scope of practice from a clinical model to one of medication therapy management, identified initially through their separate submissions, then subsequently in a list of mutual requests. The Association also requested several additional changes. The requests for authorization to access controlled acts were limited to specific purposes. A key distinction between the two submissions was the College’s request to authorize pharmacists’ activities under medication therapy management as “dispensing without further authorization” and the Association’s request to refer to these activities as “prescribing”.

There was strong support from interested parties for the College’s requests on the basis of pharmacists’ competencies, education and training, as well as for increasing efficiencies within the health care system. With pharmacy education in Ontario moving toward the entry level Pharm.D. degree by 2010, medication therapy management will be even more ingrained in the curriculum. Interprofessional collaboration is the key to success of an expanded scope of practice for pharmacy. Implementing a comprehensive electronic health records system is critical to Ontario’s health system and would support interprofessional collaboration and an expanded scope of practice for pharmacy.

The RHPA and the Profession-Specific Acts—Scope of Practice Statements

The College has requested a change to the scope of practice statement in the Pharmacy Act, 1991 to reflect the additional activities that it is requesting, including access to new controlled acts. The scope of practice statement found in each profession-specific Act under the RHPA provides a frame of reference (or parameters) for the performance by regulated health professionals of their authorized acts. A regulated health professional may perform his or her profession’s authorized acts only in the course of practising within the profession’s scope of practice.

In the context of the scope of practice reviews, HPRAC would consider amending a scope of practice statement only in the following situations:

When an act is added to the list of authorized acts conferred upon a health profession, and
When HPRAC is satisfied that its criteria for a scope of practice review have been met.

This analysis would take place at the same time as HPRAC considers the expansion of a health profession’s authorized acts. That is, HPRAC will ask: does an expanded scope of practice statement

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67 OCP and OPA: Proposed Wording for HPRAC July 31, 2008; Scope of Practice Compare and Contrast.
encompass a new assessment, diagnostic, treatment or prevention opportunity for the profession that was previously prohibited? Is this expansion necessary and/or desirable?

As HPRAC has stated in its document, The Review of a Professional Scope of Practice, under the RHPA a scope of practice includes many elements, including the scope of practice statement. Based on the various elements that determine whether a scope of practice statement should be amended, HPRAC will provide the analysis and recommendations on the scope of practice statement after its determination of whether pharmacists should be granted access to the additional controlled acts being proposed.

Only after consideration of all of the specific controlled acts being proposed by the College and the Association will it be clear how, and to what extent, the scope of practice statement needs to be amended. Further, based on HPRAC’s analysis about whether pharmacists should be authorized to undertake medication management therapy activities, HPRAC will need to address how the controlled activities (prescribing or dispensing without further authorization) would be granted. This too should be addressed before any consideration of amending the scope of practice statement.

Both the College and the Association specified limits to and conditions on most of their requests for authorization to perform certain controlled acts. Their requests are grounded on the profession’s core competencies at the entry to practice level. Where they are seeking to expand their scope of practice to activities that go beyond what people may traditionally associate with the practice of pharmacy, they have indicated that any new authority should have limits imposed at the outset. HPRAC has analyzed the proposals on the basis of the limited purposes that have been specified.

HPRAC’s Approach

HPRAC grouped the College and Association requests into the following categories:

- Medication therapy management
- A minor ailments program
- Additional requests to initiate therapy.

Medication Therapy Management: What It Includes

For the purpose of its analysis, HPRAC combined the College and Association joint requests. The first requests considered are those included under the term medication therapy management.

In its submission, the College defines Medication Therapy Management, or MTM:

"...as the term that best describes the cognitive role that pharmacists play before making the decision to dispense a drug and while monitoring ongoing drug therapy. The role reaches far beyond dispensing as pharmacists must first gather information from the patient or agent or the prescriber to determine whether the prescribed drug is appropriate based on the patient’s medication and relevant history."

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68 Ontario College of Pharmacists. Submission Respecting the Scope of Practice of Pharmacists. p. (i) – Executive Summary.
The College goes on to state that, “once a diagnosis has been made, and before a drug is prescribed, pharmacists can play a key role in partnership with physicians and other prescribers to ensure that the right drug is prescribed or that, where no drug is prescribed, the patient understands why.... Monitoring patient compliance and effectiveness of medication therapy is a key component of medication therapy management.”

HPRAC’s literature and jurisdictional reviews did not uncover a universally accepted definition of medication therapy management. The terminology was first used in the United States when, in 2004, several key national pharmacy associations approved the following statement that summarizes the key activities they consider to be included in medication therapy management:

Medication Therapy Management is a distinct service or group of services that optimize therapeutic outcomes for individual patients. Medication Therapy Management Services are independent of, but can occur in conjunction with, the provision of a medication product. Medication Therapy Management encompasses a broad range of professional activities and responsibilities within the licensed pharmacist’s, or other qualified health care provider’s, scope of practice. These services include, but are not limited to, the following, according to the individual needs of the patient:

a) Performing or obtaining necessary assessments of the patient’s health status;
b) Formulating a medication treatment plan;
c) Selecting, initiating, modifying, or administering medication therapy;
d) Monitoring and evaluating the patient’s response to therapy, including safety and effectiveness;
e) Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;
f) Documenting the care delivered and communicating essential information to the patient’s other primary care providers;
g) Providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications;
h) Providing information, support services and resources designed to enhance patient adherence with his/her therapeutic regimens;
i) Coordinating and integrating medication therapy management services within the broader health care-management services being provided to the patient.

In Canada, the Alberta model of pharmacy practice is quite broad and includes several aspects of medication therapy management; the province has developed standards of practice to determine when and which medication therapy management activities are appropriate and necessary. British Columbia has also adopted pharmacy practices that enable pharmacists to maximize their full educational and professional competencies and refer to these practices as medication therapy management. Under Professional Practice Policy #58: Medication Management, a pharmacist will be authorized to adapt a

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69 Approved July 27, 2004 by the Academy of Managed Care Pharmacy, the American Association of Colleges of Pharmacy, the American College of Apothecaries, the American College of Clinical Pharmacy, the American Society of Consultant Pharmacists, the American Pharmacists Association, the American Society of Health-System Pharmacists, the National Association of Boards of Pharmacy*, the National Association of Chain Drug Stores, the National Community Pharmacists Association and the National Council of State Pharmacy Association Executives. * Organization policy does not allow NABP to take a position on payment issues.

70 See HPRAC Pharmacy Scope of Practice Jurisdictional Review. p. 3.


prescription if the action is intended to optimize the therapeutic outcome of treatment with the prescribed drug and meets the appropriate protocol.

Throughout their submissions, the College and Association claim that pharmacists are medication management experts and that this is at the core of what pharmacists are educated and trained to do. These activities include safely adapting a dosage form, dosing regimen, or dose strength to facilitate drug coverage and to authorize prescription extensions for continuing therapy. As is evidenced by the medication management schemes in other jurisdictions, the purpose for many of these activities is to ensure continuity of care to the patient.

The College and Association are requesting authorization to initiate, without supervision or delegation, the following activities as part of their role in providing medication therapy management to patients:

- **Extend** a prescription, where there are no existing refills, for continuity of care.
- **Adapt** an existing prescription to facilitate patient adherence, such as changing the dosage form (e.g. from a capsule or tablet to an oral dosage formulation for patients who have difficulty swallowing); changing the dosage regimen (e.g. from one tablet twice a day to two tablets once a day to facilitate adherence); changing the dosage form to one reimbursable by the patient’s third party drug benefit plan (e.g. capsule to tablet); and when the prescribed dose/dosage form/pack size is not commercially available (e.g. 50mg only comes in 52.5mg or 30-day pack vs. 28-day pack), based upon all available information to the pharmacist and the appropriateness for the individual patient.
- **Adjust** dosage of existing medication in response to monitoring (e.g. based on lab results).

### Medication Therapy Management in Ontario

The College and the Association maintain that pharmacists are educated and trained to do medication therapy management at the entry to practice level. The two organizations maintain that having pharmacists undertake these activities will provide continuity of patient care, decrease the strain on other health care providers, support chronic disease prevention and management and facilitate patient compliance, and increase efficiency in the health care system.\(^{73}\)

According to the College, pharmacists are currently refilling prescriptions in emergency situations to ensure continuity of care and when the patient’s physician is unavailable to approve the refill.\(^{74}\) In order to be in compliance with their registration requirements, pharmacists use their professional judgment or rely on section 29(1) of the *RHPA*, which provides exceptions to permit persons to perform controlled acts when rendering first aid or temporary assistance in an emergency (section 29(1)(a)) and assisting a person with routine activities of living (section 29(1)(e)). On a daily basis, pharmacists are called upon to use their professional judgment to take action that is in the best interests of the patient.\(^{75}\)

\(^{75}\) Professional judgment involves four key areas:
1. taking actions that are in the best interest of the patient, including the patient having an active role in the decision-making process as well as understanding all the options and choices that are available to him/her;
2. having knowledge and expertise to make the judgement;
3. making decisions that pharmacist peers would consider reasonable given the circumstances; and
4. documenting all relevant actions including what happened and why, names of the professionals with whom you conferred and when, and all outcomes.
In Ontario, the need to safely provide for authorizing refills by pharmacists has been addressed in the Draft *Pharmacist Authorization of Prescription Extensions* (PAPE) Agreement, developed collaboratively by the College, the Association, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario. The PAPE Agreement was voluntarily developed to address the need to ensure continuity of care for patients who are taking medications on a regular basis to manage a chronic disease or other continuing condition.

Based on the model in Nova Scotia\(^\text{76}\), the PAPE Agreement provides conditions under which a pharmacist may provide authorization of a prescription extension to a patient where an urgent need for patient drug therapy management exists and the prescribing physician is unavailable to provide refill authorization. The PAPE Agreement is an excellent example of interprofessional collaboration among several health professionals aimed at ensuring the continuity of care to patients, and has been submitted to the Ministry of Health and Long-Term Care for approval as a regulation. The PAPE Agreement demonstrates that the professions that are party to the PAPE Agreement recognize that pharmacists are qualified to undertake medication management activities independently, under limitations and conditions.\(^\text{77}\)

The PAPE Agreement would no longer be required in the event that the scope of practice for pharmacy is expanded to include medication therapy management activities.

The College of Nurses of Ontario wrote a letter to provide the College with its initial feedback to the May 2008 consultation.\(^\text{78}\) Extracts from this letter were provided in the College’s submission. The following outlines the College of Nurses of Ontario’s (CNO) position on the emergency provisions and medication therapy management.

We do not believe that the exception provisions listed in section 29 of the *Regulated Health Professions Act* are meant to be used to provide a regulated health profession with broad and routine access to controlled acts. It is CNO's recommendation that [the Ontario College of Pharmacists] seek legal access to the controlled acts; this approach is transparent, provides clarity to pharmacists and to other health care practitioners and protects the public - as it facilitates role clarity and [the College's] ability to govern its members with respect to the performance of these acts.

CNO's interpretation of [the College's] proposal is that pharmacists would not be initiating prescriptions, but they would alter prescriptions initiated by an authorized prescriber. This could include changes as straightforward as substitutions or, under specific circumstances, authorizing refills or adjusting doses. CNO appreciates that [the College] envisions that these activities would occur within a collaborative context and would require enhanced communication between the pharmacist and other health care providers.

We understand that there has been some groundwork on the issue of authorizing refills between the medical and pharmacy communities with the PAPE (Pharmacist Authorization of Prescription Extensions) agreement. We recommend that [the College] begin this dialogue with other prescribers.

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\(^\text{76}\) HPRAC. Pharmacy Scope of Practice Jurisdictional Review. p. 3.

\(^\text{77}\) Draft PAPE Agreement in HPRAC Submission: Scope of Practice for Pharmacy. p. 22

\(^\text{78}\) Campbell HM, Director, Practice & Policy, Ontario College of Nurses. May 27, 2008. Letter to Anne Resnick, Director, Professional Practice, Ontario College of Pharmacists.
That there is a public need for pharmacists to play a greater role in providing medication therapy management to patients does not appear to be at issue. With an aging population, the government’s emphasis on better chronic disease management, the introduction of technologies to enable patient self-testing and monitoring, and the physician shortage, patients must be able to access medication therapy management services, once they have been diagnosed by a physician. Based on their education and training, and because they are the most accessible primary care health professional, in some cases available 24/7, pharmacists are in the best position to provide these services. This has been acknowledged by many of the stakeholders who took part in the consultations – including the College of Physicians and Surgeons of Ontario, the Ontario College of Family Physicians and the College of Nurses of Ontario.

Risk of Harm

To fully address the issues and risks associated with medication therapy management activities and to determine the appropriate mechanism to grant authority for these activities, an analysis of the controlled acts of prescribing and communicating a diagnosis as outlined in the RHPA is necessary. Controlled acts are restricted to regulated health professionals who are authorized to perform them under the RHPA and their profession-specific Act. The public policy for creating the list of controlled acts under the RHPA is that these activities were deemed by the Legislature to pose a sufficient risk of harm to the public. The RHPA therefore restricts access to these activities to certain regulated health professionals in accordance with the competencies demonstrated by those professionals in their scope of practice.

Closely linked to the act of prescribing is the need to make a diagnosis. The College’s submission clearly states that pharmacists are not trained to make a differential diagnosis. This was confirmed by the educators from both the University of Toronto and the University of Waterloo. Making a diagnosis is not a core competency of pharmacists. HPRAC will fully address the controlled act of communicating a diagnosis in considering the further request by the Association to initiate therapy or to initiate a prescription as this activity raises significantly more issues concerning risk of harm to patients.

For the purpose of HPRAC’s analysis and recommendation on whether pharmacists can safely undertake medication therapy management, HPRAC does not find that these activities require a pharmacist to communicate a diagnosis. These activities would take place after an original prescription has been issued by an authorized prescriber. In order to issue the prescription, the prescriber would have had to communicate a diagnosis to the patient. Therefore, the original prescription is the basis for all of these activities.

A Question of Competence

However, extending these activities to pharmacists could potentially pose a risk of harm to the patient as the pharmacist would no longer have to check back for authorization from the prescriber. The key question to assess the potential increased risk of harm and whether it can be mitigated is whether pharmacists are competent to undertake these activities independently.

The College and Association state clearly that medication therapy management is part of pharmacists’ core competencies at the entry to practice level. The educators have confirmed that this is the case based on the rigorous four-year education curriculum and the National Qualifying Examination, administered

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Interprofessional Collaboration Phase II September 2008
Chapter 2 – Review of the Scope of Practice of Pharmacy

by the Pharmacy Examining Board of Canada and founded on “Professional Competencies for Canadian Pharmacists at Entry to Practice” by the National Association of Pharmacy Regulatory Authorities, which include the key elements of medication therapy management as part of the core competencies of pharmacy practice.

In support of the proposition that pharmacists are competent to undertake medication therapy management and that there is not an increased risk of harm when pharmacists do so, the College refers to a number of studies, including a recent study in Ontario nursing homes. The College summarizes and cites the findings of the study stating “in comparing patterns of potentially inappropriate drug therapy prescribing in community-dwelling older adults and nursing home residents in Ontario in 2001, researchers found that nursing home residents were close to half as likely to be dispensed a potentially inappropriate drug therapy as community-dwelling older adults. Clinical pharmacist services, which are mandated in the nursing home setting, were thought to be responsible for these differences.”

The College says that “Medications have been a key concern in patient safety, not only from the perspective of adverse events and interactions with other drugs, but also in accurate communication among health professionals about a patient’s medication therapy as they receive services in different health sectors.” Further, the College says that “Recognition of the expertise of the pharmacist in medication management and their role in promoting health, preventing and treating diseases, dysfunctions and disorders introduces little or no new risk to patients because, in many cases, pharmacists already perform these duties.” In support of its claim, the College says, “Patient safety will increase as more proactive involvement of pharmacists in medication therapy management and other medication-related activities have been found to reduce medication-related problems.

The literature review revealed emerging anecdotal evidence in support of the merits and the potential of enhancing scopes of practice for pharmacists as a mechanism to bring about positive change in patients’ health arising from improvements in the continuity of patient care and models of care delivery. At present, there is little evidence-based research, given that enhanced roles for pharmacists are still in their infancy in Canada and elsewhere.

A review of American and Canadian jurisdictions indicates an emerging trend that enhances pharmacists’ role and authorizes them to undertake some or all medication therapy management activities. All provinces and territories except Prince Edward Island, Ontario and the Yukon allow pharmacists to authorize further extension of a prescription where there are no existing refills for continuity of care. All except Prince Edward Island, Saskatchewan, Ontario and the Yukon allow pharmacists to adapt an existing prescription to facilitate patient adherence (such as changing the dosage form), and this policy is

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currently under consideration in Saskatchewan. British Columbia, Alberta, Quebec, Newfoundland and Labrador authorize pharmacists to adjust the dosage of existing medication in response to monitoring; Saskatchewan, Manitoba and Nova Scotia are considering granting pharmacists the authority to do so.

Collaboration and Safeguards

As the jurisdictional review demonstrates, many other provinces in Canada have adopted, or are in the process of considering, some degree of authorization for pharmacists to undertake medication therapy management. Some provinces limit the activities to refilling a prescription when the prescriber is not available. Other jurisdictions have used various mechanisms to grant the authority to pharmacists. While the approach varies among the jurisdictions, all of them provide details for the types of medication therapy management activities specifically authorized, the level of communication required with a physician as well as other standards of practice.

For example, under Standard 1 of Alberta’s *Health Professions Act Standards for Pharmacist Practice* (2007), pharmacists must “work collaboratively with other regulated health professionals whenever required to serve the best interests of the patient.” Standards 11, 12, 13 and 14 outline standards of practice to document medication therapy management decisions, the rationale for those decisions, the follow-up plan and the notification of any other health professional in the patient record. In British Columbia, Professional Practice Policy #58 outlines seven elements of protocol, including documentation of medication therapy management, rationale, follow-up plan and notification of other health professionals, required for pharmacists to engage in medication therapy management activities.

The written submission received by HPRAC from the Ontario College of Family Physicians (OCFP) in August 2008 indicates that the OCFP is generally supportive of expanding the scope of practice of pharmacists. The OCFP states:

> Our specific comments are highlighted in the table on the following pages, where we have included our general expression of support, but we are also highlighting words of caution, should HPRAC accept the College’s submission and as we move forward with scope of practice changes, with the goal of enabling interprofessional collaboration. The focus must be on pharmacists working in collaboration with the patient’s family physician to ensure that safety is first and foremost. Moreover, recognizing how lack of understanding of each other’s scope of practice is in itself a barrier to IPC, expanding and changing scope of practice discussions should continue in interprofessional collaborative forums, to ensure that all pharmacists endorse the changes and feel prepared to accept new responsibilities and to ensure that family physicians are aware and engaged.

Concerning the specific request for adapting and refilling prescriptions, the OCFP states that patients should only be serviced by pharmacists who have an established collaborative relationship with that

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86 Alberta, Quebec, New Brunswick and Nova Scotia, for example. See HPRAC Pharmacy Jurisdictional Review of Requests, August 2008.

87 Saskatchewan, Manitoba, Newfoundland and Labrador, for example. Ibid.


89 *Health Professions Act Standards for Pharmacist Practice*. p. 13-17.


Chapter 2 – Review of the Scope of Practice of Pharmacy

patient’s family physician.\textsuperscript{93} The submission also states that the OCFP agrees with the College’s rationales for seeking the expanded scope of practice including the following statements made by the College in their submission that the proposals are intended to: reflect current practice, education and competencies of pharmacists, increase patient access to timely health services, increase efficiencies within the system and enhance cost-effectiveness by decreasing duplication, and clarify and enhance pharmacist accountability.”\textsuperscript{94}

**Recommendation:**

1. That pharmacists be authorized to undertake medication therapy management.

**Authorization to Order Laboratory Tests for the Purpose of Medication Therapy Management**

As part of medication therapy management (adjusting medication), the College and Association are seeking authority to order laboratory tests for the purpose of monitoring and managing a patient’s medications. This is currently being done by pharmacists in hospitals, family health teams and in long-term care facilities under medical directives and delegation. In these settings pharmacists work collaboratively with other health professions to ensure safe patient care.\textsuperscript{95}

The College maintains that having pharmacists adjust medication on the basis of laboratory test results would meet a significant public need by alleviating the need for patients to wait to see their physicians to adjust medication for the purpose of managing a chronic disease.

The examples provided by the College and the Association help demonstrate the context in which having the authority to order laboratory tests for medication therapy management could enhance patient care and safety and ensure that the patient is achieving the best results from their medication treatment plan. The College said that:

> Managing medication therapy involves knowing which drugs require monitoring through laboratory tests and subsequent dosage adjustments depending on the test results. In existing models involving professional collaboration and care, pharmacists order blood work for patients whose medications require ongoing blood monitoring and adjust dosages of chronic medications depending on the results (e.g. INR clinics, renal clinics). The College would strongly support pharmacists in both community and hospital practice settings being able to initiate orders for laboratory testing within the ambit of medication therapy management and collaborative practice.\textsuperscript{96}

A letter submitted to HPRAC by Mark Kearney, a pharmacist practising at the Queensway Carleton Hospital (the Prescription Shop) in Ottawa,\textsuperscript{97} provides examples of situations facing patients and the role

\textsuperscript{93} Ibid, OCFP, p. 9
\textsuperscript{94} Ibid, OCFP, p. 9
\textsuperscript{95} For example, Ontario Pharmacists Association Family Health Team Resource Kit. The Association of Family Health Teams of Ontario. \url{http://www.aftho.com}; Letter to HPRAC from Mark Kearney, B.Sc.H, M.Sc, B.Sc., Pharm, Queensway Carleton Hospital, Ottawa, Prescription Shop, Received August 7, 2008, Past President of the Ottawa-Carleton Pharmacists’ Association.
\textsuperscript{96} OCP. HPRAC Submission – Scope of Practice for Pharmacy. p. 19
\textsuperscript{97} Letter to HPRAC from Mark Kearney, B.Sc.H, M.Sc, B.Sc., Pharm, Queensway Carleton Hospital, Ottawa, Prescription Shop, Received August 7, 2008, Past President of the Ottawa-Carleton Pharmacists Association
that pharmacists could play if they were granted a broader scope of practice. Mr. Kearney practices in both a hospital and community setting. He provides evidence that supports collaborative practice with physicians in the hospital pharmacy environment. He states that medical directives and delegation work extremely well in ensuring patient safety and continuity of care based on a strong level of collaboration amongst the health care providers, although they are limited to the patients who are under the care of participating physicians.

In the context of community pharmacy, his examples demonstrate the challenges patients face as a result of the limited scope of practice of pharmacists. His submission provides details of a five-week delay for a serious medication-related problem to be addressed. In this case, if the pharmacist had been authorized to order the laboratory test, the patient would have saved more than two weeks of waiting to receive the proper treatment from her physician.

As Mr. Kearney wrote:

Despite having her initial problem identified and addressed, [the patient’s] new medication therapy necessitated ongoing monitoring and adjusting…, which she could not obtain in a timely manner. Allowing pharmacists to order lab tests, to perform point-of-care testing, and to adjust doses of chronic medications would have allowed for an immediate solution to this need. 98

The College and Association claim that pharmacists have the competencies to order laboratory tests at the entry to practice level. In discussions with the educators, it was confirmed that reviewing the results and adjusting medication based on the laboratory test results was taught and tested as part of the four-year curriculum of the pharmacy programs at the University of Toronto and University of Waterloo. The educators further confirmed that as part of the National Qualifying Examination, pharmacists were examined on their ability to review and analyze test results and determine the appropriate adjustment to the medication. The educators confirmed, however, that there is a gap in the education and training of students when it comes to determining which tests to order. The educators acknowledged that given the extensive knowledge-base of pharmacists, it would not require much additional post-registration education in order to develop the necessary knowledge and skill to determine which tests should be ordered in which circumstances.

It was noted by the College and the Association that certain pharmacists have already sought additional training in chronic disease management (diabetes monitoring) and that pharmacists practising in hospitals, family health teams and long-term care settings are already experienced in this activity as a result of working under a physician or nurse practitioner. Some pharmacists are separately certified to provide chronic disease management for patients with diabetes under a specific program protocol.

Part of the difficulty in assessing the risk of harm from granting authority to pharmacists to order laboratory tests is the fact that the College and Association did not specify the specific tests that pharmacists need to be authorized to order if they are to effectively provide medication therapy management to their patients. The Association limited its request to ordering tests for the purpose of monitoring and managing patient’s medications, while the College specified that pharmacists only need to be authorized to order relevant tests in the context of providing medication therapy management to patients.

Emphasis on Collaboration

The lack of specificity about which laboratory tests to order must be balanced with the risk of harm associated with ordering laboratory tests, interpreting the results and adjusting the medication on the basis of those results. The issue is whether pharmacists are competent to order the tests, interpret the results, adjust the medication and advise and counsel their patients accordingly. Other than the opinion in a letter from the President of the Ontario Medical Association (see below), on balance the stakeholders who attended the consultations and submitted written responses to HPRAC said that pharmacists are competent (have the skills, education and training) to adapt medication on the basis of laboratory test results. They also strongly recommend that the medication therapy management role be done in the context of interprofessional collaboration – that is, that pharmacists be required to collaborate with the original prescriber and to report their activities relating to the patient’s medication management.

Both the Association and the College acknowledge the need to work collaboratively with other health professionals in an expanded role. The Association, for example, states:  

In order to be able to monitor and modify prescriptions based on lab results, pharmacists should be authorized to order lab tests, especially when working with those patients without a primary care physician. Working collaboratively with other healthcare professionals, a duplication of labs can be avoided, and in the near future, when electronic health records are an integrated part of daily healthcare, there will be no concerns, as everyone will have access to the same information. It is important to note that pharmacists will continue to work in collaboration with other healthcare providers in an enhanced scope of practice model, as inter-professional communication is key to successful patient-centred healthcare.

In June 2008, Ken Arnold, President of the Ontario Medical Association (OMA), wrote to Deanna Williams, Registrar of the College, indicating the OMA’s concerns over the proposed expansion of the scope of practice of pharmacists. With respect to medication therapy management, the OMA “recommends that the proposed regulation explicitly address this issue by mandating that it occur in the context of a collaborative practice as a limitation upon an act. In other words, pharmacists should only be permitted to engage in these activities if there is some form of prescriber consultation.”

Subsequently, the OMA made a more detailed submission to HPRAC in August 2008. In this, the OMA made several general comments on the possible risks associated with pharmacists undertaking medication therapy management. On the ordering of laboratory tests, the OMA says that a physician must be consulted prior to the ordering of any tests. The OMA cites the potential for duplication if pharmacists are independently authorized to order laboratory tests.

Concerning ordering laboratory tests, the OMA said:

…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 [College] 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

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100 Letter dated June 5, 2008 to Deanna Williams from Ken Arnold, MD, President of the Ontario Medical Association.
101 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 and Pharmacy, August 2008.
Chapter 2 – Review of the Scope of Practice of Pharmacy

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 College 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.

The letter from the College of Nurses of Ontario\textsuperscript{102} cited in the College’s submission provided further comments on its position on ordering and receiving laboratory tests and the implications of the expanded role more generally:

[The College] proposes that pharmacists be authorized to order and receive laboratory tests to monitor drug therapy and adjust dosages in certain conditions. CNO recommends that [the College] develop these conditions in consultation with other providers of the health care team, specifically prescribers. We would also emphasize that our support is contingent upon appropriate two-way communication between the pharmacist and other health providers.

Overall, we believe that this type of expanded role for pharmacists would work best in a system that is integrated and would be most appropriate in settings where pharmacists are directly involved as part of the larger health care team. This provides direct access to the client's health record and the other professionals involved in medication therapy. These types of settings include hospitals, Family Health Teams and Community Health Centres. We view the absence of an integrated electronic health record as a key barrier to implementing these initiatives in the community (i.e. retail) pharmacy sector.

Further to the CNO’s submission, HPRAC received written submissions from the Ontario Branch of the Canadian Society of Hospital Pharmacists (OBCSHP)\textsuperscript{103} and from a hospital clinical pharmacist from the Markham Stouffville Hospital.\textsuperscript{104} These submissions confirm that hospital pharmacists have been specifically trained and are currently undertaking many of these activities under delegation from physicians and other regulated health professionals. The OBCSHP confirms that the collaborative team model works effectively in hospitals where professionals rely on each other’s complementary skills. The OBCSHP states that pharmacists have the education, training and skills required to initiate, modify, monitor and manage drug therapy and further cites a recent study that shows that pharmacists are critical to improving patient health outcomes by reducing medication-related adverse events.\textsuperscript{105} The OBCSHP supports a collaborative prescribing role for pharmacists and sees collaboration as key in an enhanced role for pharmacists.

HPRAC acknowledges the issues and concerns raised by the stakeholders about medication therapy management generally, as well as about the authority to order laboratory tests to undertake certain

\textsuperscript{102} Campbell H.M, Director, Practice & Policy, Ontario College of Nurses. May 27, 2008. Letter to Anne Resnick, Director, Professional Practice, Ontario College of Pharmacists.

\textsuperscript{103} Ontario Branch of the Canadian Society of Hospital Pharmacists Response to HPRAC regarding the Ontario College of Pharmacists Submission to HPRAC.

\textsuperscript{104} Letter from Dr. Malcolm Ng, R.Ph., M.B.A.,B.Sc.(Pharm) B.Sc.(Microbiology), Clinical Pharmacist, Markham Stouffville Hospital to HPRAC.

\textsuperscript{105} Bond CA, Raehl CL. Clinical pharmacy services, pharmacy staffing and hospital mortality rates. Pharmacotherapy 2007; 27:481-93 as cited by in the Ontario Branch of the Canadian Society of Hospital Pharmacists Response to HPRAC regarding the Ontario College of Pharmacists Submission to HPRAC.
Chapter 2 – Review of the Scope of Practice of Pharmacy

medication therapy management activities. HPRAC is convinced that with the appropriate post-registration training, pharmacists can be trained to order laboratory tests in the context of medication therapy management. In jurisdictions where medication therapy management has been authorized, pharmacists are also granted the authority to order laboratory tests. HPRAC also sees the need for interprofessional collaboration and communication with the original prescriber as key to any standards, limitations and conditions that would need to be developed under the enabling regulatory framework. The PAPE Agreement sets out the established principles that need to be adhered to in granting pharmacists the authority to independently undertake medication therapy management.

HPRAC recognizes that it is imperative to address these issues in community pharmacy, where patients are not required to see the same pharmacists and where there could be a risk of patients using different pharmacists for different medications, thereby potentially increasing patient risk. Again, these matters can be addressed in detailed standards of practice, limitations and conditions developed through an interprofessional standards committee.

Recommendation:

2. That pharmacists be authorized to order laboratory tests for the purpose of medication monitoring and management.

Electronic Health Record

Coordination of information relating to patients, including information about tests that have been ordered and the results of those tests, speak to the overall need for electronic health records. As noted in the CNO’s response, this issue is worthy of specific mention in the context of the expanded scope of practice. It is especially a concern for community pharmacists who do not or may not have a permanent working relationship with a physician, family health team or a nurse practitioner clinic, as there could be no ongoing monitoring of the patient by a physician. Ontario does not have a comprehensive patient electronic health record linking pharmacies to other health care providers. This has been cited as a key barrier to fully integrating patient care and ensuring prompt and timely reporting to physicians and other primary health care providers about the care and management of the medication needs of their patients. The need for a comprehensive electronic health record was considered to be one of the key structural barriers to successfully enhancing the scope of practice of pharmacists to include medication therapy management, and ensuring collaborative care.106

Medication Therapy Management: “Dispensing without Further Authorization” or “Prescribing”?  

The College recommends that medication therapy management functions be performed as “dispensing without further authorization from a prescriber subject to terms and conditions.” The Association has recommended that these functions be performed as “prescribing.”

The College says that its position to not actively pursue prescribing rights for pharmacists was based on responses from pharmacists who were concerned that prescribing traditionally follows the process of conducting a differential diagnosis and the acknowledgement that they were not trained to make a

106 OCP. HPRAC Submission – Scope of Practice of Pharmacy. P. 30; OPA Submission to HPRAC on Scope of Practice of Pharmacy. p. 9.
differential diagnosis. The College maintains that its members are not competent to perform the controlled act of communicating a diagnosis and that the perception among the public and other health professions is that prescribing must follow a differential diagnosis.\footnote{OCP, HPRAC Submission – Scope of Practice of Pharmacy. p. 40.}

HPRAC considered two issues in reaching its conclusions on how pharmacists should be granted the authority to undertake medication therapy management:

1. Is it necessary for an Ontario regulated health professional to be authorized to perform the controlled act of communicating a diagnosis when the health professional is authorized to perform the controlled act of prescribing a drug? and

2. What is the distinction between the controlled act of “communicating a diagnosis” and “communicating the results of an assessment”, which is in the public domain (that is, is not a controlled act)?

In considering the first question as to whether it is necessary for an Ontario regulated health professional to communicate a diagnosis in order to be authorized to perform the controlled act of prescribing a drug, HPRAC weighed a number of considerations.

HPRAC understands the College’s concern about the link between differential diagnosis and prescribing drugs and the pharmacists’ current lack of training in making a differential diagnosis. In certain situations prescribing drugs indeed follows the communication of a differential diagnosis to a patient that he or she has a disease or disorder. For example, a physician may prescribe drugs after communicating to a patient that the patient has high cholesterol. Pharmacists are not trained nor permitted to communicate a high cholesterol diagnosis to a patient. Nor is the College or Association asking HPRAC to authorize pharmacists to initiate prescriptions for drugs for conditions such as high cholesterol. However, for the purposes of prescribing drugs for medication therapy management, pharmacists do not need to make or communicate a differential diagnosis identifying a disease or disorder as the cause of a patient’s symptoms, as the patient may already be aware of such a diagnosis.

Under Ontario law, communicating a diagnosis and prescribing are two separate controlled acts. There is no explicit requirement in the \textit{RHPA}, the \textit{Drug and Pharmacies Regulation Act}\footnote{R.S.O. 1990, c. H.4.}, or the various profession-specific Acts for the controlled act of prescribing to be based on making or communicating a diagnosis. Indeed, certain health professions in Ontario are currently authorized to prescribe drugs but are not authorized to communicate a diagnosis (midwifery and chiropody). For example, a midwife is currently authorized to prescribe clotrimazole to treat a fungal infection that may afflict her patient during pregnancy, but the midwife is not authorized to communicate a diagnosis identifying the infection as a cause of the patient’s symptoms.\footnote{Midwifery Act, 1991, S.O. 1991, c. 31 O. Reg. 884/93.} There are no restrictions on the midwife in making an assessment of the patient’s physical symptoms and prescribing drugs to address the symptoms, so long as the midwife does not identify a fungal infection as the cause of the symptoms.

For the reasons discussed below, HPRAC concludes that just as midwives may make an assessment and prescribe a limited number of drugs, pharmacists can make a similar assessment when prescribing drugs for medication therapy management and not be required or expected to make a differential diagnosis or to communicate a diagnosis.
HPRAC therefore finds that the controlled act of “communicating a diagnosis” is not a mandatory complementary authorized act that must be conferred in order to grant authorization to prescribe certain drugs.

HPRAC then considered the distinction between the controlled act of “communicating a diagnosis” and “communicating the results of an assessment”, which is in the public domain.

Neither “communicating a diagnosis”, “diagnosis” nor “assessment” are defined terms in the RHPA or any of the profession-specific Acts. Consequently, a review of the legislative intent of the RHPA provides an interpretation of the purpose of the inclusion of “communicating a diagnosis” as a controlled act as opposed to “making and communicating an assessment”.

In its 2001 Report to the Ontario Minister of Health and Long-Term Care entitled “Adjusting the Balance: A Review of the RHPA”, HPRAC provided a detailed review of the legislative intent of the controlled act of communicating a diagnosis and the reasons why the legislation did not create the controlled act of “making the diagnosis”. In its report, HPRAC reached several conclusions as to the implications of what is included in the controlled act of communicating a diagnosis, the difference between an assessment and communicating a diagnosis, and the risk of harm associated with the controlled act of communicating a diagnosis.

As part of its analysis, HPRAC cited the Hansard from the Standing Committee hearings as well as excerpts from the Health Profession Legislation Review that led to the development of the framework of the RHPA. The Health Professions Legislation Review Committee defined an assessment as “the evaluation of a patient’s physical or mental state in order to determine whether a treatment within the health professional’s scope of practice is appropriate to the patient’s condition and if so in what manner it ought to be applied or administered and includes communication of the evaluation to the patient and his or her representative.”

The following excerpts provide HPRAC’s analysis as to what the controlled act of communicating a diagnosis entails and what the difference is between communicating a diagnosis and providing an assessment:

The Standing Committee discussions also help explain the difference between “diagnosis” and “assessment”. Legal counsel for the Ministry states that the Health Professions Legislation Review used the word “assessment” to mean something that all regulated providers could engage in. Since that was something different than diagnosis, they included the word “assessment” in the scope of practice statements of most regulated professions and gave it a particular definition.

By including the definition of assessment and the word “assessment” in these individual health profession Acts, the Health Professions Legislation Review intended to signal that even if health professionals could not perform the controlled act of communicating a diagnosis, they could nevertheless perform an assessment and communicate the results of the assessment to their patients.

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Pharmacists could therefore be permitted to evaluate the patient’s physical state in order to determine whether a treatment within the pharmacist’s scope of practice is appropriate to the patient’s condition and, if so, in what manner it ought to be applied or administered. Pharmacists would not communicate to a patient a diagnosis identifying a disease or disorder as the cause of symptoms in an individual. If the scope of practice of pharmacists is extended to include prescribing and medication therapy management as the Association has requested, then pharmacists could prescribe drugs for medication therapy management through the evaluation and treatment of the patient’s physical state without making an unauthorized communication of a diagnosis.

For example, a pharmacist may determine that a refill of a prescription is necessary to treat the patient’s condition based on the patient’s medication history and may authorize a refill of the prescription. In this situation, the pharmacist has prescribed drugs based on an assessment of the patient’s medication history, without actually communicating a diagnosis of a disease or a disorder as the cause of the patient’s symptoms. Indeed, communicating a diagnosis in this instance is not necessary as the patient is already aware of the disease or disorder requiring medication.

On the basis of a number of factors – including effective patient care, collaborative activity between professions, transparency and clarity in legislative language and purpose, trends in other jurisdictions and the legislative and regulatory framework in Ontario – HPRAC has concluded that the medication therapy management activities proposed by the College and the Association should be authorized.

To permit this activity, section 4 of the Pharmacy Act, 1991 will require amendment to authorize the additional controlled act of prescribing, as set out in the regulations. The regulations made under the Pharmacy Act, 1991 would authorize pharmacists to prescribe for the purpose of medication therapy management with prescribed standards, limitations and conditions to be established in the standards of practice of the profession.

HPRAC did not agree with the College that the controlled act relating to medication therapy management should be described as “dispensing without authorization”. HPRAC’s conclusions were reached by taking into account the following factors:

- “Dispensing without authorization” does not reflect the substance of the activity being performed.
- This descriptive would require a new controlled act and amendments to other complementary legislation to include the new controlled act of “dispensing without authorization” and to ensure it is recognized and valid.
- To protect the public interest and to avoid the risk of misleading the public, the activity being performed should be described as clearly as possible.
- Under the Drug and Pharmacies Regulation Act (DPRRA)\(^\text{112}\), a “prescription” is defined as a direction from a prescriber directing the dispensing of any drug or mixture of drugs for a designated person (or animal).\(^\text{113}\)
- “Prescription” is defined in the Drug Interchangeability and Dispensing Fee Act (DIDFA)\(^\text{114}\) as a direction from a person authorized to prescribe drugs within the scope of his or her practice of a health discipline directing the dispensing of a drug or mixture of drugs for a specified person.

\(^{113}\) Ibid., section 1(1).
\(^{114}\) R.S.O. 1990, c. p.23.
• A “prescriber” is defined in the DPRA as a person who is authorized under the laws of a province or territory of Canada to give a prescription within the scope of his or her practice of a health discipline.\(^{115}\)

• By adjusting the dosage form of the drug from a capsule to a tablet or by refilling a prescription without authorization, a pharmacist would be making a decision or direction about how the drugs are to be dispensed, as opposed to only dispensing the drugs as directed by a prescriber. The pharmacist would be prescribing.

Other changes that will be required include amendments to the Laboratory and Specimen Collection Centre Licensing Act and its regulations to authorize pharmacists to order laboratory tests for the purpose of medication monitoring and management.

The specific laboratory tests that pharmacists should be authorized to order should be developed by the College, in collaboration with other regulated health professionals through an interprofessional standards committee. Details of the controlled act of prescribing should be included both in regulation and through standards of practice that are developed with the participation of other health professionals.

**Summary of HPRAC’s Findings on Medication Therapy Management**

HPRAC endorses the need and opportunity for pharmacists, as one of the most accessible regulated health care professionals, to play a greater role in primary health care. HPRAC is persuaded that pharmacists in Ontario are highly educated and that their formal education and training have evolved to incorporate the skills and judgment required to undertake medication therapy management. Pharmacists have the potential to address an increasing public need for access to health care services related to medication therapy and continuity of patient care.

HPRAC notes that there is some evidence of increased risk of harm by having pharmacists undertake medication therapy management without delegation or supervision. However, on balance, HPRAC is confident that any additional risks can be addressed by the detailed standards, limitations and conditions that would be developed by the College through an enabling regulatory framework – including the role of interprofessional collaboration, mandated communication with the original prescriber, and post-registration education. HPRAC therefore recommends that pharmacists be authorized to undertake medication therapy management activities as an essential part of their scope of practice and that interprofessional collaboration in setting standards and in practice be a key element of this activity.

HPRAC considers that medication therapy management will allow pharmacists to:

• authorize the further extension of a prescription, where there are no existing refills, for continuity of care.

• adapt an existing prescription to facilitate patient adherence, such as changing the dosage form (e.g. from a capsule or tablet to an oral dosage formulation for patients who have difficulty swallowing); to change the dosage regimen (e.g. from one tablet twice a day to two tablets once a day to facilitate adherence); to change the dosage form to one reimbursable by the patient’s third party drug benefit plan (e.g. capsule to tablet); to change the dosage when the prescribed dose/dosage form/pack size is not commercially available (e.g. 50mg only comes in 52.5mg or 30-day pack vs. 28-day pack), based upon all available information to the pharmacist and the appropriateness for the individual patient.

\(^{115}\) *Ibid.*
• adjust the dosage of existing medication in response to monitoring (e.g. based on laboratory test results).

A Minor Ailments Program for Ontario

Background

Both the College and the Association have requested that Ontario consider implementing a minor ailments program similar to the model in Britain that is regulated by the Royal Pharmaceutical Society of Great Britain. In general, these programs allow pharmacists to consult and provide drug and non-medication therapy to patients suffering from minor ailments.

There are a number of community minor ailments schemes in operation in Britain. These are programs in which patients complaining of minor ailments – such as athlete’s foot, constipation and dermatitis – visit the pharmacist for consultation and over-the-counter medication to treat the ailment. While minor ailments schemes are in place in a limited number of communities, the programs have commonalities that would likely be adopted by any national scheme:

• There is a formal, written protocol detailing the scheme,
• Pharmacists can intervene in three ways: advice, supply of medicines and referral to a primary care physician,
• Some schemes provide vouchers for patients to use at the pharmacy, and
• A formulary of allowable medicines is agreed upon for the scheme.

The College provides a summary of the British minor ailments scheme:

Minor Ailments Schemes were piloted in Britain in the early 2000s. These minor ailments schemes enable patients who are exempt from prescription charges to receive treatment for common illnesses free of charge direct from a community pharmacy. The minor ailments and drug benefits vary with the jurisdiction. The ailments can include acne, allergies, athlete's foot, back pain, bites, burns, colds, simple viral infections (e.g. cold sores), colic, conjunctivitis, constipation, contact dermatitis, cough, cystitis, diaper rash, diarrhea, dyspepsia, earache, ear wax, eczema, fever, hemorrhoids, hayfever, headaches, head lice, indigestion, mouth ulcers, nasal congestion, oral thrush, scabies, sore throat, strains, teething, threadworms, urinary tract infections, vaginal thrush, and warts. While the products prescribed under this scheme generally are not prescription-requiring by law, they may require a prescription in order for the patient to obtain drug coverage by the NHS.

… [The purpose of the minor ailments scheme is that] it relieves pressure in primary care by discouraging patients from seeing physicians for minor ailments. In April 2006, minor ailments schemes became one of the four core services in the community pharmacy contract, meaning that it would be offered by every community pharmacy in Scotland. In England, the government recently proposed that minor ailments schemes be commissioned from community pharmacies in

every primary care trust. As of March 2007, only 24 percent of all pharmacies held such contracts.

The British minor ailments scheme is authorized by the National Health Service (NHS), the national body responsible for all health care services across England, Scotland and South Wales. NHS Trusts operate the health services in local areas.

According to the Royal Pharmaceutical Society of Great Britain (RPSGB), pharmacists have an important role to play in providing alternative support for patients in a convenient and accessible manner from their local community pharmacy. The RPSGB outlines the challenge that the NHS has in helping people with minor ailments and the potential solutions. It also provides examples of some of the minor ailments schemes in place in Britain and some of the common features:

A variety of different approaches has been developed to date to suit local circumstances:
- Every scheme has a formal, written protocol setting out agreed arrangements;
- The interventions available to pharmacists are usually of three main types: advice, supply of medicines and referral to a GP;
- Referral onto a scheme can include direct referral by the practice receptionist, nurse, GP, community pharmacist, or self-referral by the patient;
- Arrangements are generally included for fast-track referral back to the GP, if this is required. With self-referral, there are arrangements for formal notification of pharmacy consultations back to the GP practice and primary care organisation;
- Some schemes provide patients with a voucher to take to the pharmacist;
- A formulary of medicines that can be supplied under the scheme is drawn up and agreed locally. If prescription-only medicines are to be included, a patient group direction can be used.

The College cites preliminary data on the British minor ailment schemes that demonstrates increased access by the public to necessary health services for minor ailments, increased access to physicians by patients who are more seriously ill, and overall cost savings to the NHS. IMS Health analysed anonymous patient records from its database of 210 general practices across the United Kingdom, covering four million patient records and 190 million prescriptions. Data from 500,000 patients who had consulted their physician about a minor ailment suggested that, in 2006/2007, 51.4 million general practitioner consultations a year were solely for minor ailments. Estimated at eight minutes per consultation, this represents 18 percent of a general practitioner’s workload or an hour a day for each general practitioner. The total cost to the NHS of these consultations is £1.8bn and 80 percent of this (£1.5bn) is attributable to the cost of the general practitioner’s time. In addition, 10 minor ailments are responsible for 75 percent of the cost of minor ailments consultations and 85 percent of the cost of prescriptions for minor ailments, which include: back pain, indigestion, dermatitis, nasal congestion, constipation, migraine, acne, cough, sprains and strains, and headaches.

119 OCP. Submission to HPRAC – Scope of Practice of Pharmacy. p. 56-57.
121 Ibid.
123 OCP. Submission to HPRAC – Scope of Practice of Pharmacy. p. 35.
There are many variations of minor ailments schemes in Britain, including differences in the types of minor ailments that are included and the standard clinical protocol for how a pharmacist must deal with each minor ailment. For example, the NHS Borders Trust, in *Pharmacists Formulary For Minor Ailments Scheme* (May 2006), provides a detailed formulary listing the types of ailments that are included, a detailed assessment and treatment protocol for each minor ailment including when to refer to a physician, and when and which type of medication can be prescribed. The detailed formularies are developed by the health professions that take part in the minor ailments scheme. In current schemes, the pharmacist typically completes a pro forma (similar to a prescription) for each patient seen under the scheme, which records patient details and treatment supplied. The patient must complete either a declaration of exemption or confirm the amount paid, usually on the reverse of the pro forma, which serves both as a record of service provided and an invoice, and is submitted to the local Primary Care Trust on a monthly basis. All pharmacies are reimbursed the costs of the medicines, but the method by which the consultation costs are paid varies among schemes. Some pay a fee per consultation and others have banded fee structures depending on the number of consultations carried out. Some schemes also pay an annual or one-off retainer.\textsuperscript{124}

**Authorization to Prescribe Schedule I (Prescription Drugs) to Treat Minor Ailments**

In Britain, pharmacists are authorized to initiate prescriptions under a detailed agreement with the local trust, based on interprofessionally developed formularies and treatment protocols. Alberta has recently authorized pharmacists, who have satisfied an additional registration requirement, to prescribe Schedule I drugs and blood products.\textsuperscript{125}

The College has not requested authorization to initiate Schedule I prescriptions for minor ailments management – this request was contained in the Association submission, which seeks limited authorization to prescribe Schedule I drugs for minor ailments. Examples from the Association of conditions that warrant pharmacist-initiated therapy for minor ailments with a Schedule I drug include:\textsuperscript{126}

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne (mild – moderate)</td>
<td>Creams and gels: tretinoin, clindamycin, benzoyl peroxide &gt; 5%</td>
</tr>
<tr>
<td>Athlete’s foot</td>
<td>Terbinafine cream</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>1% and 2.5% hydrocortisone cream, &amp; other topical steroids, Compounded creams such as clotrimazole/HC</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>Proton Pump Inhibitors, H\textsubscript{2} Receptor Antagonists</td>
</tr>
<tr>
<td>Eye infections</td>
<td>Ophthalmic antibiotics: fusidic acid, erythromycin, gentamycin, tobramycin</td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td>Zinc sulfate with HC ointment and suppositories</td>
</tr>
<tr>
<td>Oral mucocutaneous HSV infection</td>
<td>Antivirals: acyclovir cream/ointment/tablets, valacyclovir tablets, foscarnet tablet</td>
</tr>
<tr>
<td>Pain</td>
<td>NSAIDs, COX-II inhibitors, cyclobenzaprine</td>
</tr>
<tr>
<td>Urinary Tract Infections (as per established protocol)</td>
<td>Short-course antibiotics, Phenazopyridine</td>
</tr>
<tr>
<td>Vaginal Yeast Infection</td>
<td>Single-dose fluconazole</td>
</tr>
</tbody>
</table>

\textsuperscript{124} National Prescribing Centre. Community Pharmacy Minor Ailments Schemes. p. 6.  
\textsuperscript{125} *Pharmacists Profession Regulation*, AR 129/2006 Section16(3) Subject to subsection (4), a clinical pharmacist is authorized to perform, within the practice of pharmacy and in accordance with the Pharmacists' Standards of Practice, the restricted activities of prescribing a Schedule I drug and prescribing blood products if the clinical pharmacist:  
(a) has provided evidence satisfactory to the Registrar of having successfully completed the Council requirements to prescribe Schedule I drugs and blood products, and  
(b) has received notification from the Registrar that the authorization is indicated on the clinical register.  
\textsuperscript{126} OCP and OPA. Proposed wording for HPRAC. July 31, 2008. The Association notes that this is not an exhaustive list of minor ailments that pharmacists have the capability to treat, rather, it is a list of conditions for which pharmacists should be able to initiate therapy with Schedule I drugs.
The College has suggested a minor ailments scheme for Schedule II and III, or non-prescription drugs, which is comparable to services that are now provided by pharmacists. Both the College and the Association maintain that any minor ailments scheme in Ontario would need the government’s support and must be developed through an interprofessional committee of health care providers, including representatives from the Ontario Medical Association, the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the Registered Nurses’ Association of Ontario and the Nurse Practitioners’ Association of Ontario.

The literature and jurisdictional reviews indicate that there are a number of approaches to expanding the role of pharmacists to include initiating a prescription. One of the common threads is the central role that interprofessional collaboration plays from designing the system to being an integral part of the delivery of patient care.

HPRAC accepts that granting pharmacists the authority to initiate a prescription for minor ailments poses additional, but manageable, patient risks. Unlike medication therapy management, in a minor ailments program there would not be an original prescription from another prescriber; rather the pharmacist would be the first point of contact for the patient and, thus, initiating drug therapy. Several safeguards would need to be in place to minimize the risk of harm to patients, including interprofessionally developed formularies, clinical protocols and mandatory referral protocols.

HPRAC recognizes the benefits of a minor ailments program and considers it consistent with the government’s priorities in addressing current health care challenges, including access to family physicians and emergency room wait times. The development and implementation of a minor ailments program is an excellent example of the potential of interprofessional collaboration at both the clinical and regulatory level.

HPRAC sees the potential for a minor ailments program to increase access to safe primary care to patients in Ontario. Some individuals in the consultative process expressed concern about having pharmacists prescribe, largely based on the belief that prescribing was necessarily linked to communicating a diagnosis. HPRAC has rejected that view based on its review of the legislative framework in Ontario. Both the College and the Association maintain that the kinds of minor ailments under consideration are the same ones for which pharmacists are currently counselling patients in their day-to-day practice.

Both the College and Association submit that pharmacists are appropriately trained for initiating a prescription for minor ailments. The Association states that “pursuant to in-depth consultations with their patients, pharmacists have been assessing their symptoms and, when appropriate, prescribing Schedule II and III medications for decades. Expansion of this role to include a limited number of minor ailments that might require treatment with Schedule I medications can be easily supported through enhanced training at the faculty level, perhaps in a multidisciplinary fashion alongside medical and nursing students.” The organizations also make it clear that not all pharmacists will undertake these activities, and see the expanded scope as voluntary and not mandatory. The College maintains that it is and will always be the pharmacist’s responsibility to practise within his or her individual scope of practice.

In addition to Britain, jurisdictions in Canada have authorized the initiating of prescriptions by pharmacists. As noted, Alberta authorizes pharmacists to prescribe Schedule I drugs within their educational preparation and training. There is no limit or formulary of allowable drugs for a pharmacist who has obtained prescribing authority. In Quebec, pharmacists can initiate therapy for minor ailments if
it is accompanied by a prescription or a particular protocol. Saskatchewan and Manitoba are considering changes to allow pharmacists expanded authority under a minor ailments scheme.

Pharmacists are trained to assess a patient’s need for treatment of a minor ailment. However, if the best evidence is that a Schedule I drug is required for treatment, pharmacists are not able to prescribe it and must rely on over-the-counter (Schedule III) or behind-the-counter (Schedule II) options. HPRAC is convinced that some Schedule I drugs should be included in a minor ailments program formulary, and acknowledges that many other elements would need to be in place before such a program could be implemented, including the appropriate regulatory checks and balances to address any additional risks to the public.

HPRAC recognizes that this request is forward-looking. It is also consistent with the trend in other jurisdictions that allow pharmacists to practise to the fullest extent of their training and education, including the authority to prescribe under certain conditions. HPRAC also sees granting limited prescribing authority to pharmacists as a means to address existing public need and benefiting those Ontarians who do not have a family physician.

Recommendation:

3. That steps be taken towards the introduction of a minor ailments program in Ontario. To that end:

   • That the College and the Association, in collaboration with the Ontario Medical Association, the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the Registered Nurses’ Association of Ontario, the Nurse Practitioners’ Association of Ontario, other health professions, facilities, educators and Ministry representatives develop the details of a program that would be suitable in Ontario, including: the list of minor ailments that pharmacists could treat; an agreed formulary including Schedule I, II and III drugs; protocols for referral to and communication with other health professionals, obtaining patient consent, and record-keeping; options for reimbursement for professional services; and educational and competency requirements and quality assurance – among other matters. The working group should also outline an implementation plan, including any pilot projects that might be required, along with communications elements to advise patients of the program.

   • That the College incorporate practice standards for a minor ailments program in its regulatory regime, and that those standards be developed with the participation of other health professions.

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Additional Requests for Initiating Therapy

Smoking Cessation

The Association has proposed that pharmacists be granted the authority to initiate therapy for smoking cessation (including prescribing Schedule I drugs such as varenicline and bupropion). The College did not include this request in its submission.

This proposal raises similar issues to those addressed in HPRAC’s consideration of a minor ailments program, including competency, risk of harm and conflict of interest (see discussion of conflict of interest later in this section). The Association maintains that pharmacists are trained and educated to provide assistance and counselling to patients who want to quit smoking. Both the Association and the College cite examples of smoking cessation programs that pharmacists have been involved in and that have been offered in a pharmacy. Pharmacists claim that they are seeking authority to provide the best available treatment in those instances, which may include a Schedule I prescription drug. The Association further contends that initiating smoking cessation medication does not require communicating a diagnosis as the patient is self-identifying.

HPRAC acknowledges that this request is progressive. HPRAC also sees it as consistent with the trend in other jurisdictions that allow pharmacists to practice to the fullest extent of their training and education, including the authority to prescribe under certain conditions. HPRAC also views granting limited prescribing authority to pharmacists as having the potential to address existing public need and benefiting the many Ontarians who do not have access to a family physician.

While HPRAC does not see smoking cessation as a minor ailment, it recognizes the benefits of authorizing pharmacists to counsel patients on the most effective smoking cessation medication and behaviour. The government has placed a focus on health promotion and getting people to quit smoking as one of its key priorities. In light of the Minister’s request for HPRAC to review those non-physician professions that prescribe or use drugs in the course of their practice, HPRAC will include its examination of this matter in that review and will report to the Minister of Health and Long-Term Care in 2009.

Recommendation:

4. That pharmacists be authorized to initiate therapy for smoking cessation, including prescribing Schedule I drugs.

Travel Prophylaxis

The Association has proposed that pharmacists be authorized to initiate therapy for travel prophylaxis subject to additional training (including prescribing Schedule I drugs such as mefloquine, chloroquine, atovaquone/proguanil, relevant vaccines, acetazolamide, antibiotics in case of traveller’s diarrhoea). The College did not include this request in its submission.

Authorizing pharmacists to initiate therapy for travel prophylaxis subject to additional training concerns two specific controlled acts: prescribing a drug, and administering a substance by injection.
HPRAC heard the example of interprofessional collaborative care associated with a pharmacy-based travel clinic that operates at Carleton University. The pharmacist operates under a medical directive from a physician and notes that the medical directive is effective but only applies to patients who are on the physician’s roster; therefore, the clinic cannot offer its services to walk-in patients.

The Association said that pharmacists would need advanced competencies and that the additional education is primarily focused on travel expertise and not the medication being provided. Programs in the United States offer specialized training in travel, including mapping skills, disease prevention and control and pharmacological information. A key element in providing specialized travel advice is the need to maintain up-to-the-minute information about the risks in travel destinations around the world. Prescribing travel prophylaxis does not require a pharmacist to communicate a diagnosis as the medications are preventative or to be taken by a patient who must self-diagnose when faced with certain symptoms while travelling.

The Association acknowledges that there is no demonstrable public need for pharmacists to be authorized to initiate travel therapy at this time, but indicated that there could be a benefit to smaller communities if a pharmacist, in collaboration with a physician, could provide the services and not require patients to go to a larger urban centre to get the expertise and medication. Very few pharmacists, in conjunction with physicians, provide these services now.

In Canadian jurisdictions, initiating therapy for travel prophylaxis by pharmacists is not common. Alberta pharmacists are authorized to perform travel therapy if the proper prescribing authority has been obtained, but no other provinces grant pharmacists authorization to do so. British Columbia, Manitoba and Nova Scotia are considering policy packages that include travel prophylaxis. Pharmacists in Ontario are able to provide these services through a medical directive and an ongoing relationship with a physician.

While HPRAC sees this as a potential matter for consideration in the future, it does not find any compelling reason to recommend this proposal at this time.

**Recommendation:**

5. That pharmacists not be authorized to independently initiate therapy for travel prophylaxis.

**Administering a Substance through Injection and Inhalation for Patient Education and Demonstration**

The College has requested access to the controlled act of administering a substance through injection or inhalation for the limited purposes of providing patient education. This request is based on the current role that pharmacists play in counselling patients on the use of chronic medication and devices, which may include demonstrating the administration of insulin in the case of an injection, or instruction on the use of emerging new medications that are inhaled rather than swallowed. The College says that pharmacists are limited in their ability to counsel and educate their patients since they cannot demonstrate proper usage.
Chapter 2 – Review of the Scope of Practice of Pharmacy

HPRAC concurs that any increased risk of harm to the public by having pharmacists authorized to administer substances through injection or inhalation for the purpose of patient education and demonstration could be addressed through education and training. Along with nurses, physicians and other professionals, pharmacists can play a major part in responding to the public need to ensure that individuals are educated on the proper use of their medication, most particularly in managing chronic diseases such as diabetes. This will help to improve patient compliance and proper use of medication.

Training, educating and counselling patients to appropriately use medication is a core competency of pharmacy. Pharmacy students are educated and trained to demonstrate proper usage of medication. The current limitation on a pharmacists’ scope of practice is a barrier to pharmacists being able to efficiently and effectively counsel their patients. Few concerns were raised about this request in any of the submissions or consultation sessions.

The Ontario Medical Association opposed this request on the basis that pharmacists should not be granted such a limited purpose authorization. In its August submission to HPRAC, the OMA states that it “does not see the need for the addition of these controlled acts given the exception that exists under the 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.” HPRAC, however, accepts the views of other health professions that argue that the exceptions under section 29(1)(e) should not be used as a mechanism to circumvent the professional accountability required by explicitly authorizing controlled acts.

HPRAC was persuaded that it is in the public interest to grant authority to pharmacists to administer drugs through injection and inhalation for the limited purpose of patient education and demonstration. HPRAC also found that the drugs covered by this authority should be determined through detailed standards, limitations and conditions, including the appropriate education requirements developed through the enabling regulatory framework.

Recommendation:

6. That pharmacists be authorized to administer drugs through injection and inhalation for the purpose of patient education and demonstration.

Administering Drugs through Injection and Inhalation to Provide Routine Injections to Patients

The Association has requested that pharmacists be granted broader access to the controlled act of administering drugs through injection and inhalation to provide routine injections when it is in the patient’s best interest, appropriate in the pharmacist’s professional judgment, and subject to regulations pertaining to patient privacy and the confidentiality and security of personal health information.

Both the Association and the College state that authorization for this request should be granted only upon satisfaction that the pharmacist can demonstrate competence. The College acknowledges that a

128 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 and Pharmacy, August 2008.
Chapter 2 – Review of the Scope of Practice of Pharmacy

A pharmacist is not competent at the entry to practice level. The College cites the SARS outbreak as one example of the kind of emergency where community pharmacists as the most accessible regulated health care professionals might be able to assist the public by administering any vaccines that may be available.

In one of the consultation sessions, the Chair of the Association’s Board of Directors, Ken Burns, provided two non-emergency examples as to why pharmacists should be authorized to do routine injections. The first example was the recently approved Gardacil vaccine, and the other was the Hepatitis A and B (Twinrix) vaccine that requires multiple injections over the course of a year. Patient compliance would be increased if pharmacists could perform the injection as patients have to come to the pharmacy regardless to purchase the drug for injection. If a patient is not able to arrange an appointment with the physician within the time allotted for the second injection, they may have to begin the vaccine process again.

The College argues that by expanding the scope of practice to administering an injection, pharmacists will be better prepared to act in times of emergency to help patients with their medication issues and to inject immunizations as they will be educated and trained to do this.

While the above examples are helpful in demonstrating the value of granting this additional role to pharmacists, there was not a compelling case made for the need for additional immunization services, given the availability of public health nurses, registered nurses and nurse practitioners to perform these functions. Further, currently under sections 28 and 29 of the RHPA, pharmacists have the authority to perform such acts in an emergency.

Both the College and the Association say that pharmacists are not currently trained and educated to administer injections. The educators confirmed this but made two points: (1) that because of their strong base in pharmacology and physiology, practicing pharmacists could be educated and trained to perform injections in a continuing education program; and (2) that the University of Toronto and the University of Waterloo are revamping their curricula for the 2010 starting class in the entry level Pharm.D. program. The educators say that if pharmacists are authorized to administer a drug by injection and inhalation, then the newly registered students will be trained, educated, and competent to undertake such activities safely. Changes may also be needed to augment the National Association of Pharmacy Regulatory Authorities’ Professional Competencies for Canadian Pharmacists at Entry to Practice and the National Qualifying Exam administered through the Pharmacy Examining Board of Canada.

HPRAC did not find that there was a compelling case to enhance the pharmacy scope of practice to include routine immunizations at this time. However, it is in the public interest to ensure that pharmacists have the core competencies to undertake these activities when needed for emergencies.

**Recommendation:**

7. That pharmacists not be authorized to perform routine immunizations.
Performing a Procedure on Tissue Below the Dermis for Purposes of Self-Care and Chronic Disease Monitoring, including the Use of Lancing-Type Devices

Both the College and Association support this request. The Association further states that the purpose for this authorization should be limited to patient self-care and chronic disease monitoring, including the use of lancing-type devices. They further maintain that pharmacists are educated and trained to perform this activity at the entry to practice level.

The controlled act of performing a procedure on tissue below the dermis is the act that enables a limited number of other regulated health care professionals to undertake a wide range of activities including anything from pricking the finger, to taking a blood sample, to surgery. Pharmacists recognize that they are not competent for most activities that would be authorized under this act, and have limited their request to training and educating patients and using devices that are becoming more and more available as a result of emerging technologies to monitor chronic diseases.

The College and the Association state that pharmacists are already doing this now but often have to demonstrate the use on themselves, which is not as effective as demonstrating on the patient directly. HPRAC believes that granting pharmacists this authority will further enhance their role in providing medication therapy management services to their patients and ensure that patients administer and monitor their medication properly.

Recommendation:

8. That pharmacists be authorized to perform a procedure on tissue below the dermis for the limited purpose of patient self-care education and chronic disease monitoring, including the use of lancing-type devices.

Initiating a Prescription for Schedule II and III Drugs Where Required for Reimbursement under Drug Plans

HPRAC recognizes the nature of this request and the impact it could have on patients who would otherwise have to pay for over-the-counter medications. HPRAC heard examples of the need for patients to purchase expensive dip-sticks for diabetes management that, without a prescription, would not be covered by a third party insurer. HPRAC does not believe that this issue directly relates to a pharmacist’s scope of practice, nor does it relate to activities that will enhance interprofessional collaboration. HPRAC is therefore not recommending any changes to the scope of practice of pharmacy to grant authority to pharmacists to prescribe Schedule II and III drugs solely for the purposes of patient reimbursement under an insurance plan.

Recommendation:

9. That pharmacists not be authorized to prescribe Schedule II and III drugs solely for the purposes of patient reimbursement under an insurance plan.
Scope of Practice Statement

Based on HPRAC’s recommendations to expand the scope of practice for pharmacy in Ontario by authorizing prescribing for the purpose of medication therapy management and a minor ailments program, administering drugs by injection and inhalation for the purposes of education and demonstration, and performing a procedure on tissue below the dermis with limits and conditions, HPRAC recommends that the scope of practice statement for pharmacy be amended.

Recommendation:

10. That the scope of practice statement for pharmacy be amended.

Other Issues Considered

A few related issues must be addressed in considering the development of medication therapy management or a minor ailments program in Ontario.

Conflict of Interest – Prescribing and Dispensing

The first issue concerns the potential for an inherent conflict of interest that would arise if a pharmacist exercised the authority to prescribe, as they would then be in a position to both prescribe and dispense the medication. This issue was identified in Alberta, where a standard of practice was developed to ensure that, when a pharmacist both initiated therapy and dispensed the drug, it was done in the best interests of the patient.\(^{130}\)

HPRAC considers this to be an important issue but one that can be addressed by the interprofessional standards committee and the other regulatory checks and balances that would be put in place. HPRAC sees the additional authority to prescribe as requiring a specific, further definition of conflict of interest in the College’s standards of practice, in addition to existing regulation and Code of Ethics requirements under the College. The College Code of Ethics provides, for example\(^ {131}\):

- Principle One: The patient's well-being is at the centre of the member's professional and/or business practices. Each member develops a professional relationship with each patient at a level that is consistent with his or her scope of practice. Patients have the right to self-determination and are encouraged to participate in decisions about their health.

- Principle Two: Each member exercised professional judgment in the best interest of the patient, at a level consistent with his or her scope of practice to ensure that patient needs are met.

\(^ {130}\) Health Professions Act Standards for Pharmacist Practice (2007). Standard 15. p. 18. Under Standard 15, a pharmacist who prescribes a drug based on the pharmacist’s own assessment must have the drug dispensed by another pharmacist unless the pharmacist is satisfied that adhering to this standard will compromise the health of the patient, or the patient chooses to have the pharmacist dispense the drug.

Chapter 2 – Review of the Scope of Practice of Pharmacy

• Principle Eight: Each member practices under conditions which neither compromise professional standards nor impose such conditions on others.

Economic Impact

HPRAC notes that the requests from the College and Association have important economic implications. Currently, pharmacists are compensated for dispensing through a dispensing fee, which varies depending on a number of market factors. The provincial government limits the dispensing fee that will be reimbursed for those individuals who are eligible to receive certain benefits (senior citizens and individuals in the Ontario Disability Support Program) and limits the amount that pharmacies can be reimbursed for dispensing certain drugs. Pharmacists are also compensated by the government for reviewing the medication of patients (who meet certain criteria) under the MedsCheck program.

The Association indicates that the current reimbursement model and compensation method may not be appropriate for compensating pharmacists for the professional services they would provide in either an expanded medication management role or in a minor ailments program. Tying compensation to the dispensing of drugs in these circumstances, rather than to the cognitive services that patients rely on, leads to some ethical concerns. An approach comparable to that of the MedsCheck program may be more appropriate. As indicated in the British minor ailments scheme and in the Alberta experience, various options could be considered.

Since HPRAC does not make recommendations as to how a profession should be compensated or how patients should be reimbursed for the cost of such services, this is a matter that will require discussion between the government and the Association. HPRAC appreciates that a profession should not be expected to undertake additional activities that improve patient care and safety without being fairly compensated. This will have to be addressed by the Ministry of Health and Long-Term Care in parallel with its consideration of HPRAC’s advice from the review of the scope of practice of pharmacy.

The College and the Association have requested that pharmacists be added to the list of health care providers under the Ontario Health Insurance Program (OHIP). HPRAC has not addressed this request and will not make a recommendation on this other than to note that the issues of compensation and funding are pertinent. The government will need to consider what, if any, services ought to be covered under OHIP as it reviews HPRAC’s advice.

Health Care Consent Act, 1996

As a result of HPRAC’s recommendation to expand the scope of practice for pharmacy to include access to the controlled act of prescribing for medication therapy management and to take steps towards the introduction of a minor ailments program, HPRAC recommends that the Health Care Consent Act, 1996\(^\text{132}\) be amended to include pharmacists as “health care practitioners” who provide “treatment” or “health care” for which consent is required. HPRAC has concluded that the pharmacy profession has evolved to include “treatment” as it is interpreted under that Act, and that pharmacists therefore must comply with the Health Care Consent Act, 1996 to ensure patients’ rights are respected.

\(^{132}\) http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96b02_e.htm
Chapter 2 – Review of the Scope of Practice of Pharmacy

Recommendation:

11. HPRAC recommends that the Health Care Consent Act, 1996 be amended to include pharmacists as “health care practitioners”.

University of Waterloo Faculty of Pharmacy

In its review of the scope of practice of pharmacy, HPRAC noted that regulations under the Pharmacy Act, 1991 regarding students and interns refer only to those who are students or graduates of the Faculty of Pharmacy at the University of Toronto, and do not include the new Faculty of Pharmacy at the University of Waterloo.

Recommendation:

12. That the Minister take steps to update the regulation to recognize all pharmacy students and interns at universities in Ontario.

Conclusion

HPRAC appreciates the thorough and detailed work presented to it by the College and the Association, and also the comprehensive discussion and analysis provided by numerous individuals and organizations who reviewed the proposals for enhancing the scope of practice of pharmacists in Ontario.

Those who participated in all parts of the province, including the College and Association, underlined that collaboration and communication between professionals in their clinical settings and by their regulators are fundamental, not only to the proposals for change, but to their implementation. HPRAC agrees, and has incorporated those sentiments in its recommendations for change.

HPRAC has also taken note of the consistent and repeated calls for an electronic health record as a key facilitator of that collaboration, and as an essential communications element.

In general, HPRAC’s recommendations to the Minister on the scope of practice for pharmacy recognize not only the changes in the profession since the RHIPA was introduced, but the significant contributions that pharmacists can make to primary patient care as a result.

Implementation Proposals

To implement HPRAC’s recommendations, the following changes to statutes and regulations are proposed:

1. That section 3 of the Pharmacy Act, 1991 be repealed and the following substituted:


Scope of practice

3. The practice of pharmacy is the promotion of health and the prevention and treatment of diseases, disorders and dysfunction through the monitoring and management of medication therapy; the custody, prescribing, compounding and dispensing of drugs; and the provision of health care aids and devices and education related to their use.

2. That section 4 of the *Pharmacy Act, 1991* be repealed and the following substituted:

**Authorized acts**

4. In the course of engaging in the practice of pharmacy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Dispensing, selling or compounding a drug or supervising the part of a pharmacy where drugs are kept.
2. Skin prick testing for the purpose of educating patients on the use of health care aids and devices and for the purpose of monitoring chronic diseases.
3. Administering, by injection or inhalation, a substance for the purpose of patient education or demonstration.
4. Prescribing drugs as prescribed in the regulations.

3. That the *Pharmacy Act, 1991* be amended by adding the following sections:

**Additional requirements for authorized acts**

4.1. A member shall perform a procedure under the authority of paragraphs 2, 3 or 4 of section 4 in accordance with any requirements prescribed in the regulations.

4.2. A member shall not perform a procedure under the authority of paragraph 3 of section 4 unless the substance is prescribed by a member of a College as defined in the *Regulated Health Professions Act, 1991* who has the authority to make the prescription.

**Individual scope of practice for pharmacists**

4.3. A member is responsible for identifying the limits of his or her educational preparation and competencies, and for resolving situations beyond his or her expertise by consulting with or referring patients to other health care professionals.

4. That the *Pharmacy Act, 1991* be amended by adding the following section:

**Regulations**

14.(1) Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council may make regulations,

(a) designating the drugs that may be prescribed by members in the course of engaging in the practice of pharmacy;

(b) designating the circumstances in which a member may prescribe drugs in the course of engaging in the practice of pharmacy; and

(c) specifying requirements for the performance of procedures under the authority of paragraphs 2, 3 or 4 of section 4.
Individual drugs or categories
14.(2) A regulation made under paragraph 14(1)(a) may designate or specify individual drugs or categories of drugs.

5. That section 1.5 of Ontario Regulation 681/93 under the Pharmacy Act, 1991 (Professional Misconduct) be repealed and the following substituted:

1.5. Prescribing, dispensing or selling drugs for an improper purpose.

6. That section 22 of Ontario Regulation 681/93 under the Pharmacy Act, 1991 (Professional Misconduct) be repealed and the following substituted:

22. Contravening, while engaged in the practice of pharmacy, any federal or provincial law or municipal by-law with respect to the distribution, sale, prescribing or dispensing of any drug or mixture of drugs.

7. That section 28 of PART IV (General) of Ontario Regulation 202/94 under the Pharmacy Act, 1991 be amended by adding the following:

(4) It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of paragraphs 3 or 4 of section 4 of the Act must: (a) provide satisfactory evidence of successful completion of a program that meets approved criteria; and (b) ensure the procedure performed does not exceed the level of training completed.

(5) It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of paragraphs 2, 3 or 4 of section 4 of the Act must ensure the procedure is performed in accordance with any standards of practice established by the College from time to time.

(6) A holder may only prescribe drugs under the authority of paragraph 4 of section 4 of the Act for the purposes of medication therapy management, treating minor ailments, smoking cessation therapy or as otherwise prescribed in the regulations.

(7) For the purposes of section 28(6),

“medication therapy management” means professional activities and responsibilities of the member designed to optimize therapeutic outcomes for a patient according to the needs of the individuals being treated as set out in detail in the standards of practice developed by the College;

“minor ailments” means a designated list of conditions for which a member is authorized to prescribe designated drugs as set out in regulation and in the standards of practice developed by the College; and

“smoking cessation therapy” means professional activities and responsibilities of the member designed to assess, initiate and monitor the most appropriate therapy for smoking cessation, including the prescribing of designated drugs as set out in regulation and in the standards of practice developed by the College.

8. That Ontario Regulation 202/94 under the Pharmacy Act, 1991 be amended by adding the following:
PART IX

STANDARDS OF PRACTICE

52. The College shall develop, establish and maintain standards of practice for those procedures performed under the authority of paragraphs 2, 3 and 4 of section 4 of the Act.

53. The standards of practice referred to in section 52 shall be developed on the recommendation of the Pharmacy Standards Committee.

54. For the purposes of section 53, the College shall establish the Pharmacy Standards Committee referred to in section 53 and shall appoint the membership of the Pharmacy Standards Committee, which shall include, at a minimum, one or more:

   a) members of the Council;
   b) members of the College (including practitioners and educators);
   c) persons who are not and have not been members of the College or of the Council;
   d) members of the College of Physicians and Surgeons of Ontario, approved by the College of Physicians and Surgeons of Ontario, who practice family medicine;
   e) members of the College of Nurses of Ontario, approved by the College of Nurses of Ontario; and
   f) members of the College of Medical Laboratory Technologists of Ontario, approved by the College of Medical Laboratory Technologists of Ontario.

55. The College shall post the following on its website:

   a) the standards of practice referred to in section 52; and
   b) a list of those members who are authorized to perform a procedure under the authority of paragraphs 2, 3 and 4 of section 4 of the Act.

9. That paragraph 9(1)(a) of Ontario Regulation 682 under the Laboratory and Specimen Collection Centre Licensing Act be amended by adding the following:

   (iv.3) at the request of a pharmacist, in respect of a test specified in Appendix F.

10. That Ontario Regulation 682 under the Laboratory and Specimen Collection Centre Licensing Act be amended by adding Appendix F.

11. That paragraph 4(2)(b) of Ontario Regulation 683 under the Laboratory and Specimen Collection Centre Licensing Act be amended by adding the following:

   (iv.3) a pharmacist,

12. That PART III – PERSONS PRESCRIBED TO ORDER TESTS of Ontario Regulation 207/94 under the Medical Laboratory Technology Act, 1991 be amended by adding the following:

   5. A member of the Ontario College of Pharmacists.

13. That section 2(1) of the Health Care Consent Act, 1996 be amended by adding the following:

   (s.1) a member of the Ontario College of Pharmacists,
14. That the Minister of Health and Long-Term Care, in consultation with the Ontario College of Pharmacists, amend sections 30, 31 and 32 of PART IV Ontario Regulation 202/94 under the *Pharmacy Act, 1991* to recognize University of Waterloo students and interns in addition to those from University of Toronto.
Chapter 2 – Review of the Scope of Practice of Pharmacy
# Review of the Scope of Practice of Midwifery

## Index

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPRAC’s Central Response</td>
<td>80</td>
</tr>
<tr>
<td>Background on Maternity Care in Ontario</td>
<td>80</td>
</tr>
<tr>
<td>Current Competency Requirements for Midwives</td>
<td>86</td>
</tr>
<tr>
<td>Regulation of Midwifery in Ontario</td>
<td>88</td>
</tr>
<tr>
<td>Midwifery’s Current Scope of Practice in Ontario</td>
<td>90</td>
</tr>
<tr>
<td>Barriers to Midwifery Practice</td>
<td>91</td>
</tr>
<tr>
<td>What the CMO Has Proposed</td>
<td>93</td>
</tr>
<tr>
<td>What HPRAC Learned from Research</td>
<td>96</td>
</tr>
<tr>
<td>Perspectives from the Consultations</td>
<td>100</td>
</tr>
<tr>
<td>An Enabling Regulatory Framework</td>
<td>103</td>
</tr>
<tr>
<td>HPRAC’s Observations</td>
<td>107</td>
</tr>
<tr>
<td>HPRAC’s Approach</td>
<td>109</td>
</tr>
<tr>
<td>Clarity, Authorization for Specific Activities and Procedures, and New Controlled Acts</td>
<td>110</td>
</tr>
<tr>
<td>Requests Related to High Risk Births and Emergency Situations</td>
<td>113</td>
</tr>
<tr>
<td>Requests for Amendments to Other Legislation</td>
<td>117</td>
</tr>
<tr>
<td>Communicating a Diagnosis within the Scope of Midwifery Practice</td>
<td>121</td>
</tr>
<tr>
<td>Amendments to the Scope of Practice Statement</td>
<td>122</td>
</tr>
<tr>
<td>Breaking Down the Barriers</td>
<td>125</td>
</tr>
<tr>
<td>Conclusions</td>
<td>128</td>
</tr>
<tr>
<td>Implementation Proposals</td>
<td>128</td>
</tr>
</tbody>
</table>
Chapter 3 – Review of the Scope of Practice of Midwifery

Review of the Scope of Practice of Midwifery

The College of Midwives of Ontario (CMO), in collaboration with the Association of Ontario Midwives (AOM), submitted a response to HPRAC’s questionnaire on the scope of practice review for midwifery. HPRAC carefully considered the contents as well as the findings of extensive research and consultation in developing its recommendations.

HPRAC’s Central Response

Ontario’s midwives have a significant role to play in primary maternity care during normal, healthy pregnancies. HPRAC recommends that midwives acquire additional tools to strengthen their role as primary, low risk maternity care providers, as regulatory and structural barriers to their practice are removed. HPRAC does not find that the expansion of the scope of midwifery practice into high risk, complex care is supported by their current training and clinical experience. However, HPRAC recommends that the government encourage, fund and support new models of interprofessional primary maternity care, and involve midwives, along with obstetricians, family physicians, nurses and nurse practitioners, social workers, lactation consultants and others in maternity care in their development. An interprofessional approach, whether in a birthing centre or through a networked team, can be a positive way to alleviate pressure on maternity care in Ontario.

Background on Maternity Care in Ontario

Primary maternity care in Canada is in a state of crisis. Over the past 15 to 20 years, demographic and other social trends have had a significant impact on the provision of maternity care. These trends include:

- The increase in the age of women giving birth in Canada,
- A decrease in fertility rates,
- An increase in multiple births,
- An increase in the number of babies requiring medical attention in intensive care units,
- Human resource shortages among maternity care providers, and
- Regional disparities in the provision of maternity care services.

As a result, the sustainability of maternity care is threatened, creating an urgent need to implement multi-dimensional and multi-jurisdictional solutions to these problems. The CMO submission says: “Midwives are primary maternity care providers and should be relied upon as a significant part of the interprofessional solution to Ontario’s maternity care crisis.”

Growing Shortage of Maternity Care Providers

Over the past 25 years, Ontario has recorded a significant drop in the proportion of births attended by family physicians. The number of family physicians attending births decreased by 43 percent from 1992

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Chapter 3 – Review of the Scope of Practice of Midwifery

to 1999. By 2003/2004, only 6.9 percent of family physicians billed the Ontario Health Insurance Plan (OHIP) for more than one birth.  

This shift has affected patterns of practice among Ontario’s obstetrical specialists. Obstetricians are responding to shortages of other maternity care providers by increasing the number of women they see and, in areas where recruitment has become more challenging, by increasing the amount of time spent on-call. Currently, obstetricians attend over 80 percent of all births. Indications are that the shortage of these specialists will become severe in the near future, with at least 34 percent of obstetricians planning to retire in the next five years. Moreover, the number of obstetricians and gynecologists performing deliveries in Ontario declined by 9 percent between 1992 and 2002, while the number of practitioners remained constant, indicating a trend by the profession to decrease involvement in this area.

Interventions in Labour and Childbirth

Advances in medical technology have been accompanied by more interventions in labour and childbirth. Ontario has significantly higher rates of medical intervention in the birthing process than do other parts of Canada. Caesarean section rates in Canada reached 26.3 percent in 2005/2006, up from 17.6 percent in 1993, with Ontario above the average at 27.8 percent. There are several reasons given for this increase, including a growing proportion of expectant mothers who are obese, the increase in the age of women giving birth, requests for caesarian sections on demand, fewer family physicians delivering babies and the unwillingness of younger obstetricians to be on-call for deliveries 24 hours a day, seven days a week. Moreover, a higher rate of first birth caesarian sections magnifies future rates of this procedure as repeat surgeries are performed in later pregnancies.

At the same time, social and cultural influences have made some women insecure about their ability to give birth without technological intervention. Yet it is increasingly recognized that interfering with the normal physiological process of labour and birth increases the risk of complications for mother and baby.

Healthy, low risk pregnant women are expected to have a normal pregnancy and birth. While there may be differing views on what “normal” means, professional associations are concerned about the increase in intervention during childbirth, as it introduces unnecessary risks.

The World Health Organization states that 70 to 80 percent of all pregnancies are considered low risk or normal. Currently in Ontario, approximately 82 percent of births are attended by obstetricians, 20 percent by family physicians and eight percent by midwives. Some births are attended by more than one professional. The Health Council of Canada states that “successful reform of primary health care will

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5 A National Birthing Initiative for Canada. p.10
7 OMCEP Final Report. p 35.
8 Canadian Institute for Health Information. Giving Birth in Canada: A Regional Profile.
make better use of highly qualified health professionals. However, with obstetricians attending over 80 percent of births, the current allocation and use of their high-level skills and training is inefficient.

Role of Midwives in Primary Maternity Care

In 2006/2007, 366 midwives provided care for 8 percent of the 134,141 births in Ontario. Midwives are trained to manage labour and conduct spontaneous normal vaginal deliveries in their practice settings and thus have a significant role to play in primary maternity care during normal, healthy pregnancies. They provide antepartum, intrapartum and postpartum care – that is, care before, during and after childbirth – in hospitals, maternity centres and in the woman’s home.

The expansion of midwifery services has offered women an option for maternity care for low risk pregnancies and has also helped to mitigate some physician and nursing shortages. However, the supply of midwives in Ontario does not meet the current demand for midwifery services. In 2005/2006, midwives were able to meet only 63 percent of the demand. There are not enough midwives to fill the gap left by obstetricians and family physicians who are no longer delivering babies. Both the AOM and the Ontario Medical Association (OMA) agree that by 2012, unless the human resources shortages are addressed, at least 10,000 Ontario women may have no maternity care provider to deliver their babies.

Since 1994, midwives have obtained admitting privileges at two thirds of Ontario hospitals that provide maternity care. Approximately 78 percent of midwifery clients choose to give birth in the hospital setting, while 22 percent opt for home birth. Overall, about 1.5 percent of all babies in Ontario are born at home. Given demographic and other social trends affecting maternity care, the number of births that take place in hospitals is expected to rise. Ontario’s experience in home births is comparable to that of Britain, where the rate of births taking place in the home is around 2 percent.

Multidisciplinary Collaborative Primary Maternity Care

Recent Canadian studies regard establishing multidisciplinary collaborative models for maternal and newborn care as a key strategy to address the human resources crisis in primary care in the short term and to solve the maternity care crisis in Canada in the long term. Collaborative care will enable providers – obstetricians, nurses, midwives, family physicians and others – to work efficiently and effectively to their full capabilities and can offer women higher quality of care.

The Multidisciplinary Collaborative Primary Maternity Care Project (MCP²), funded through the Primary Health Care Transition Funds of Health Canada, has been instrumental in:

12 Quoted in A National Birthing Initiative for Canada. p. 10.
14 Ontario Ministry of Health and Long-Term Care news release and Statistics Canada’s summary table, generated from CANSIM’s table 051-0004, on births and birth rate by province and territory. August 22, 2007.
15 See the Current Scope of Midwifery in Ontario, below.
17 Idem
20 A National Birthing Initiative for Canada. p. 20
21 As summarized by A National Birthing Initiative for Canada. p. 21. The Final Report of mcp² is available online: http://www.mcp².ca/english/studies_reports.asp
Chapter 3 – Review of the Scope of Practice of Midwifery

- Collecting relevant information on current multidisciplinary collaborative maternity care models,
- Developing guidelines for the establishment of multidisciplinary collaborative care models that are woman-centred and include core components with flexible contextual factors,
- Increasing communication and collaboration between individuals and associations representing the full range of maternity care providers in order to collectively champion changes to the provision of maternity services and the move to more collaborative models of maternity care,
- Identifying and reducing some key barriers to multidisciplinary collaborative maternity care,
- Setting national standards regarding terminology and scope of practice relative to maternity care, and
- Raising awareness on the benefits of multidisciplinary collaborative primary maternity care among health care providers and consumers.

In a follow-up evaluation of the MCP\(^2\), key informants from six professional associations identified facilitators and barriers to collaborative maternity care in Canada.\(^{22}\) They highlighted significant structural barriers to collaborative care, including established fee structures, liability concerns and interdisciplinary rivalry. They also concluded that strong national leadership is required to implement collaborative practice models.

The Ontario Maternity Care Expert Panel (OMCEP) was appointed in 2004 to examine and make recommendations to improve maternity care in Ontario. The OMCEP’s Final Report\(^{23}\) in 2006, *Emerging Crisis, Emerging Solutions*, addresses similar issues to the MCP\(^2\) and provides recommendations to the provincial government to address the looming maternity care crisis in Ontario.

In addition to the OMCEP’s key recommendation to establish an Office of Maternal Newborn Health, the OMCEP provides summary recommendations that call on the Ontario government, professional organizations, regulatory bodies and educational institutions to address systemic and health human resource issues in maternity care. The summary recommendations include:\(^{24}\)

**Health Human Resources:**
- Attract, support and retain maternity care providers by developing a system that values and respects all provider groups, including midwives, nurses and physicians through harmonization of regulation and liability mechanisms and creation of complementary funding schemes; and

**Structural Barriers:**
- Remove barriers to care and create structures that support:
  - The effective use of all care providers to their full scopes of practice;
  - Collaboration among professionals;
  - Innovative interprofessional models of education and clinical care founded on evidence-based guidelines and practices.

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\(^{24}\) OMCEP. *Emerging Crisis, Emerging Solutions*. Appendix A. p. 145.
Chapter 3 – Review of the Scope of Practice of Midwifery

*A National Birthing Initiative for Canada*, developed by the Society of Obstetricians and Gynaecologists of Canada (SOGC) in cooperation with maternity care partners, calls for a long-term strategy to facilitate collaborative primary maternity care models including:

- Pilot projects on collaborative care models in various health care settings based on the definition and guiding principles developed by the MCP project,
- Financial modeling initiatives,
- An evaluation framework for multidisciplinary collaborative models (ongoing and newly formed),
- Continued system development and/or improvements,
- Continued discussion and education on multidisciplinary collaborative maternity care, and
- Commitment by provinces and territories to implement multidisciplinary collaborative maternity care teams beyond the pilot projects.

Its proponents state that *A National Birthing Initiative for Canada* will have enduring impact on the delivery of maternity services in Ontario. Specific goals of the initiative are to:

- Ensure maternity care that is family centred, accessible, as close to home as possible and flexible enough to meet community needs within the primary care system,
- Facilitate maternity care human resource planning,
- Ensure that the education needs of nursing, medical and midwifery students, family physicians and obstetrical residents are met through easy access to interprofessional educational opportunities and practice within a culture of interprofessional cooperation and collaboration,
- Create mechanisms to support the philosophy of cooperation, mutual respect and trust of maternity care providers and their professional associations, regulatory bodies and educational facilities,
- Reduce barriers, including regulatory and legislative, malpractice and liability issues, funding and compensation,
- Circulate national standardized practice guidelines for all maternity care providers and establish common processes and protocols for the delivery of maternity care services, and
- Ensure women and their families are provided with information regarding choices of care available in their local communities, regions, provinces and territories.

Patient Safety and Performance Improvement

The MOREOB (Managing Obstetrical Risk Efficiently) Program “is a comprehensive, three-year, patient safety, professional development, and performance improvement program for caregivers and administrators in hospital obstetrics units. The program structure is based on the proven principles of High Reliability Organizations including: safety as the priority, effective communication, teamwork, decreased hierarchy in emergencies, practice for emergencies, and reflective learning. The program integrates evidence-based professional practice standards and guidelines with current and evolving patient safety concepts, principles and tools.” Since its inception in 2002, MOREOB has been implemented in

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25 The partners included: the College of Family Physicians of Canada, the Canadian Association of Midwives, the Association of Women’s Health, Obstetric and Neonatal Nurses (Canada) and the Society of Rural Physicians of Canada.
26 *A National Birthing Initiative for Canada*, p. 21.
27 Ibid., pp.3, 7.
28 MOREOB www.moreob.com/
146 hospitals in Canada, with 54 in Ontario and a total of 8,295 participants, 8 percent of whom are midwives.  

MORE\textsuperscript{OB} was initiated as a keystone in the SOGC’s vision of patient safety. As a next step in achieving this vision, Salus Global Corporation was formed through a partnership by the SOGC and the Healthcare Insurance Reciprocal of Canada (HIROC). The new company combines the patient and health care safety expertise of each organization.\textsuperscript{30} The MORE\textsuperscript{OB} program, has been delivered for over five years by a team of key interest groups, including the SOGC, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the Society of Rural Physicians of Canada, the Association of Women's Health, Obstetric and Neonatal Nurses, the Canadian Association of Midwives, and Accreditation Canada.\textsuperscript{31}

**Ontario Midwifery Program**

Midwifery is a managed government program in Ontario. Midwives are considered primary care providers and a referral from another health professional is not required. They can provide autonomous prenatal, intrapartum and postpartum care.

The Ontario Ministry of Health and Long-Term Care allocates an annual budget for midwifery services, education and placements in the province. Midwives work as independent practitioners in group practices that are funded by the ministry’s Ontario Midwifery Program (OMP). Each practice group has a funding arrangement with a ministry-approved non-profit agency (transfer payment agency) that receives funding from the OMP and distributes it to midwifery practice groups.

Each midwifery practice group – usually comprised of two to five midwives – then has a funding agreement with the transfer payment agency to provide services in a particular geographic area. Every year, the practice group and the agency negotiate the number of clients that the agency may refer to the group during the year. The funding for the practice group is based on the number of billable courses of care\textsuperscript{32} provided.

The fees midwives receive for a course of care include a professional component and a fixed component for overhead costs. The professional fees they receive are based on their experience;\textsuperscript{33} primary midwives receive $2,540 to $3,075 for a full course of care, as well as 18 percent of the fee that is directed toward their benefits plan. They also receive a fixed fee for a second midwife at the birth and operating expenses for each course of care.\textsuperscript{34} Midwives’ professional liability insurance covers up to $30 million\textsuperscript{35} and is provided through the AOM, with the cost reimbursed by the Ministry. Incidents requiring insurance coverage are on a per event and not a per midwife basis. As a result, midwives, as a practice group, share the professional liability for a particular event. The Healthcare Insurance Reciprocal of Canada (HIROC), the AOM’s insurer, along with the Canadian Medical Protective Association (CMPA), which provides insurance for physicians, have produced a *Joint Statement on Liability Protection for Midwives and* 

\textsuperscript{29}“A review of the national data from hospitals participating in the Salus MORE\textsuperscript{OB} obstetrical patient safety program”. Dr. J.K. Milne, MD, FRCSC, FSOGC, FACOG President and CEO Salus Global Corporation. August 2008.

\textsuperscript{30}http://salusgc.com/about_salus_history.html

\textsuperscript{31}MORE\textsuperscript{OB} www.moreob.com/program/program_overview.html

\textsuperscript{32}A course of care consists of all the necessary care provided during pregnancy.

\textsuperscript{33}There are six experience levels – experience is primarily factored in how many births a midwife undertakes per year.

\textsuperscript{34}The amount the second midwife receives is dependent upon the payment agreement with the transfer agency. It is not equivalent to the professional fee received by the Primary Midwife.

\textsuperscript{35}HIROC insures the AOM and all members. Currently, midwives’ coverage is $30 million. However, the AOM, HIROC and their legal counsel re-negotiate the amount of coverage on an annual basis.
Chapter 3 – Review of the Scope of Practice of Midwifery

Physicians. The statement recognizes the increasing interprofessional collaboration of these two professions, and ensures that all health providers providing care for the same patient have confidence in, and knowledge of each others’ professional liability insurance.

Midwives also receive an allowance for their midwifery office and second-attendant equipment but are responsible for other expenses, including registration and professional fees and tuition fees for recertification courses. After paying these expenses, full-time midwives’ earnings are between $69,000 and $92,000 in annual compensation, as well as the additional 18 percent for the benefits plan.

In 2003, the Ministry completed a program evaluation of midwifery that found that midwifery is cost-effective compared to the care provided by obstetricians and family physicians. According to Ministry estimates, the cost to the health care system of a midwife-attended birth in a hospital is about $800 less than a birth with a family physician. If a midwifery client gives birth at home, the cost is about $1,800 less. These savings are due to a 30 percent lower caesarian section rate for midwifery clients than for family physicians’ patients, an episiotomy rate that is less than half of that of a physician, 65 percent lower hospital re-admission rates than with other providers, and shorter hospital stays – including more than double the rate of early discharge of low risk patients.

In 2005/2006, the government spent $51 million on midwifery services – a 38 percent increase over the previous year. In 2007, as part of the HealthForceOntario human resources strategy, the government announced plans to expand the Midwifery Education Program (MEP) from 60 to 90 students per year by September 2008. A further $12.2 million was committed to funding 67 new graduates in 2007/2008.

Current Competency Requirements for Midwives

Core Competencies

Nationally, the Canadian Midwifery Registration Examination (CMRE) gauges Canadian midwives’ core competencies. Currently, the Ontario Minister of Health and Long-Term Care is considering regulations to require the completion of the CMRE in order to practice midwifery in the province. Students take an examination at the end of the MEP, in addition to detailed evaluations of clinical terms and written examinations after each educational term. The final examination written by Ontario MEP students is revised each year to reflect the curriculum and current practice and scope of practice.

The Canadian Midwifery Regulators Consortium has published Canadian Competencies for Midwives as a guideline for entry level midwives in Canada. Entry level midwives are defined as those who have been

42 The College of Midwives of Ontario Submission to HPRAC. p. 58 When the National exam is implemented in Ontario, some questions would be exempted: “Ontario’s differences due to delays in regulatory changes have required that certain questions be left out of the exam”.

Interprofessional Collaboration Phase II September 2008
assessed as eligible to practice in Canada after they meet provincial or territorial requirements, in the full scope of practice and without supervision requirements on their registration.  

**Educational Preparation**

The baccalaureate program in midwifery, commonly referred to as the MEP, admitted its first class in August 1993. The program is jointly offered by Laurentian University, McMaster University and Ryerson University and leads to the degree Bachelor of Health Sciences (B.H.Sc.) in midwifery. At McMaster and Laurentian, the program involves four years of full-time study, while at Ryerson the program is offered on a part-time basis.

In addition to classroom instruction, the program includes six clinical placements – five with midwifery practices and one community placement. Over the program, students are placed in more than one midwifery practice and work under the supervision of registered midwives. The community placement is divided into three one-month placements – one with an obstetrician, one in the obstetrics department of a hospital and a third in an elective setting with midwives or other health care providers. To complete the program, students must attend a specific number of births in home and hospital settings, in line with the CMO’s registration requirements.

The International Midwifery Pre-registration Program (IMPP) is a nine-month, part-time bridging program. It provides internationally educated midwives with skills assessment, information about midwifery practice in Ontario, clinical placements, mentoring and a final pre-registration exam. The IMPP is intended for experienced international midwives, fluent in English, who have practised midwifery within the past five years. It is not a re-education or retraining program.

**Accreditation**

Accreditation is a process for determining whether an educational program produces graduates who meet the required competencies for a regulated scope of practice. There is no national accrediting institution for Canadian midwifery programs at the present time. However, a National Midwifery Assessment Strategy is currently underway to assess and facilitate the entry to practice of internationally trained midwives.

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44 McMaster University. Midwifery Education Program. About the Program. http://fhs.mcmaster.ca/midwifery/about/overview.htm  
45 The community placement is divided into three ‘mini-placements’ of one month each, which combined equal the time of one full clinical placement.  
49 Ryerson University. International Midwifery Pre-registration Program. http://ce-online.ryerson.ca/ce_2007-2008/program_sites/program_gateway.asp?id=2161  
Regulation of Midwifery in Ontario

The CMO is the regulatory body for midwifery in Ontario. The CMO’s primary responsibility is the protection of the public, specifically childbearing women and their infants to whom its members provide care.\(^{51}\) Ontario midwives adhere to a philosophy of care based on “a respect for pregnancy as a state of health and childbirth as a normal physiologic process and a profound event in a woman’s life.”\(^{52}\) The core of their philosophy of care is to respect “the woman’s right to choice of caregiver and place of birth”.

Midwives attend birth in a variety of settings, including birth at home.\(^{53}\) The CMO has a policy that requires two midwives to attend each birth, regardless of setting, except in circumstances as permitted by the CMO under alternate practice arrangements.\(^{54}\) The CMO is considering changes to this policy to require one midwife and a qualified birth assistant to be present at birth, in order to alleviate pressure on primary maternity care providers.

Currently, the CMO has more than 400 registrants.\(^{55}\) In 2007, 75 students graduated from the MEP and approximately 15 completed the IMPP.

The AOM is the professional association representing Ontario midwives. To practice midwifery in Ontario, all registered midwives are required to be members of the AOM to be covered by professional liability insurance provided through the association.

Entry to Practice

There are three classes of registration with the CMO – General, General with Conditions and Supervised\(^{56}\). Registrants in the General class practice with no restrictions on their registration.

As the first step toward registration, applicants must provide proof of:

- graduation from an approved education program (MEP or IMPP) or status as a general registrant in another province, and
- certification in cardiopulmonary resuscitation, obstetrical emergency skills, and neonatal resuscitation.

Graduates of the MEP are registered initially in the General with Conditions class and are subject to the CMO’s new registrant policy. For the first year of practice, all new registrants must work full-time in an Ontario practice and must attend births with an experienced Ontario midwife. Other than these conditions, new registrants provide the full scope of midwifery care. Once the conditions have been met, the registrant’s class changes to General.\(^{57}\)

Graduates of the IMPP are registered in the supervised class for up to 12 months. Supervised midwives are fully registered members of the CMO and provide the full scope of midwifery care to their clients.

\(^{53}\) College of Midwives of Ontario. Philosophy of Midwifery Care in Ontario.
Typically, supervision lasts from six to 12 months. When the supervision plan is complete, the member’s registration class changes to either General with Conditions or General, depending on whether the midwife is still in her new registrant’s year.

**Continuing Competence and Quality Assurance**

**Maintaining Registration**

The CMO’s registration regulations require members to report birth attendance numbers upon completion of their first two years of registration. To satisfy the active practice requirement (APR), members must provide midwifery care:

(a) over a one-year period, to at least 20 women, 10 of whom the member attended as primary midwife, with five of the births occurring in a hospital and five in a residence, remote clinic or remote birth centre, or
(b) over a two-year period, to at least 40 women, 20 of whom the member attended as primary midwife, with 10 of the births occurring in a hospital and 10 in a residence, remote clinic or remote birth centre.

If they have met the APR for the initial two-year period, members will then be required to report in five-year increments. For these members, the CMO may elect to grant equivalency to APR for up to 10 births in any five-year period for activities related to the provision of midwifery care.

If members do not meet the APR or fail to report their active practice numbers, whether in the initial two-year period or in subsequent five-year periods, they will be required to take an Individualized Re-qualification Program as set out by the CMO’s Registration Committee.

Ontario midwives must also certify every two years in cardiopulmonary resuscitation, obstetrical emergency skills, and neo-natal resuscitation.

**Quality Assurance**

The Quality Assurance Program of the CMO has seven components:

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58 The supervision is imposed in order to enable the supervised midwife to meet the clinical birth numbers required by the College’s Registration Regulation, as well as to make up any gaps in clinical skills identified during the International Midwifery Pre-Registration program.


60 See the CMO’s Regulation for members in the General category: http://www.cmo.on.ca/docs/registration.pdf


62 Acceptable courses/assessments include: College of Midwives of Ontario Emergency Skills assessment, Association of Ontario Midwives: Emergency Skills Workshop (ESW), Society of Obstetricians and Gynecologists of Canada: Advances in Labour and Risk Management (ALARM), College of Family Physicians of Canada: Advances in Life Support in Obstetrics (ALSO), Ontario Midwifery Education Program Emergency Skills course, Society of Obstetricians and Gynecologists of Canada: Managing Obstetrical Risk Efficiently (MOREOB) or any course accepted by the CMO as equivalent. http://www.cmo.on.ca/docs/3fContCompESK.pdf

63 http://www.cmo.on.ca/docs/H-NRP1.pdf

64 See Quality Assurance Regulation. http://www.cmo.on.ca/docs/Sec1QualiRegulations.pdf
1) **Provision of clinical information**: members may be requested to provide information relating to the care they have given to clients.

2) **Continuing education and professional development**: members must participate in quality assurance programs.

3) **Peer case review**: members participate in at least six peer case reviews in every 12-month period. In a peer case review, a group of at least four members belonging to at least two different practice groups meets to discuss clinical care of clients.

4) **Quality of care evaluation**: members must provide every client with a quality of care evaluation form within six months of being discharged from care and request the client to complete the form and return it to the practice group.

5) **Self-assessment**: members complete self-assessments at the request of the registrar.

6) **Practice audits**: each year, the CMO selects at random members to undergo a practice audit.

7) **Remediation of behaviour and remarks of a sexual nature**: to address matters relating to sexual abuse as defined in subsection 1(3) of the Health Professions Procedural Code.

**Continuing Education**

Under section 10 of the Quality Assurance regulation made under the *Midwifery Act, 1991*:

1. A member shall participate in continuing education and other professional development activities for the purpose of maintaining and enhancing the member’s knowledge, skill and judgment.

2. Members shall maintain an annual record of their participation in continuing education and professional development activities and shall submit the record to the Committee on request.

Each year, members are required to participate in and report on three activities on the Continuing Education and Development Record. Records must be submitted to the CMO Quality Assurance Committee by January 31 of the year following the reporting year. Acceptable activities for continuing education and professional development include courses, conferences and workshops; teaching and preceptorships, professional presentations, conducting research projects, writing articles for publication, professional study groups and peer case review, hospital rounds, and self-study.

**Midwifery’s Current Scope of Practice in Ontario**

In Ontario, the legislative framework for the health professions includes an umbrella statute – the *Regulated Health Professions Act, 1991 (RHPA)* – and a series of profession-specific acts. Among other provisions in the *RHPA* is a list of authorized acts, which are health care activities that carry a substantial risk of harm if performed by unqualified people.

Each profession-specific act includes a scope of practice statement. The scope of practice statement in the *Midwifery Act, 1991* is:

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66 http://www.cmo.on.ca/docs/Section2ContiRequire.pdf

Chapter 3 – Review of the Scope of Practice of Midwifery

The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the postpartum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries. 68

The profession-specific acts also indicate the controlled acts authorized to the profession. The *Midwifery Act, 1991* provides that:

In the course of engaging in the practice of midwifery, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Managing labour and conducting spontaneous normal vaginal deliveries.
2. Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area.
3. Administering, by injection or inhalation, a substance designated in the regulations.
4. Putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period.
5. Taking blood samples from newborns by skin pricking or from women from veins or by skin pricking.
6. Inserting urinary catheters into women.
7. Prescribing drugs designated in the regulations. 69

In addition, midwives’ scope of practice is defined through regulations, CMO guidelines and standards of practice as well as other legislation. One of the College’s key standards for midwifery practice is *Indications for Mandatory Discussion, Consultation and Transfer of Care (Indications).* 70 This document provides a guide for midwives on when they are required to discuss, consult or transfer primary care responsibility for the patient to another health care practitioner.

**Barriers to Midwifery Practice**

Beyond proposals to expand midwives’ legislated scope of practice, the CMO submission discusses a series of barriers that deter midwives from carrying out the full extent of their current scope of practice. The submission identifies a number of issues as barriers 71 to midwives’ full integration and participation in the delivery of maternity care, including funding mechanisms for midwives and physicians, the hospital credentialing process and restrictive local protocols, and the provincial process for amending regulations made under profession-specific Acts.

69 *Midwifery Act, 1991*, s.4.
70 College of Midwives of Ontario. *Indications for Mandatory Discussion, Consultation and Transfer of Care*, 2000.
Chapter 3 – Review of the Scope of Practice of Midwifery

Hospital Setting

The CMO said that the integration of midwifery services in Ontario hospitals has been inconsistent. There is significant variation in hospitals in:

- restrictions in excess of CMO requirements for consultations resulting in transfer of patient care to an obstetrician,
- transfer of care to an obstetrician for women having an induction or epidural,
- inappropriate roles and tasks for midwives, such as nursing functions,
- limiting the number of midwives granted hospital privileges,
- limiting the number of births attended by midwives,
- restricting midwives’ community practice such as home birth attendance, and
- restricting midwives’ care for non-OHIP clients in hospital.

Hospital restrictions on midwives’ practice have not eased, in spite of a 2003 Coroner’s inquest recommendation\(^72\) that hospitals use the CMO’s Indications as the basis for midwifery rules. In particular, many hospitals restrict midwives’ practices by requiring a complete transfer of care for indications where the CMO rules require a consultation. The CMO said that the requirement for greater physician involvement ignores its role as regulator, with responsibility for setting standards of practice for its members.

The CMO also states that these hospital policies restrict the public’s access to midwifery care that is funded by the Ontario Midwifery Program. The result is unnecessary payments through OHIP for care that midwives have the skills and competence to provide, and are legally able to perform.

The AOM notes that since midwives rarely sit on Medical Advisory Committees in the hospitals where they practice, midwives are placed in a position where members of another profession supervise their care and are gatekeepers to access. According to the AOM, this is “an acknowledged inequity that the College of Midwives and the College of Physicians and Surgeons agreed in 1994 needed to be changed”.\(^73\)

The AOM also says\(^74\) that some hospitals resist changing their by-laws to allow midwives to be the most responsible providers. The Ontario Midwifery Program calculates that in hospitals where midwives have privileges, 24 percent limit the number of midwives granted privileges and 18 percent limit the number of midwife-attended births. In addition, midwifery practice groups are prevented from growing because hospital credentials are denied or capped.

Funding and Structure

The AOM told HPRAC that different compensation methods for midwives and other maternity care providers are barriers to midwives’ integration and collaboration with other professionals who provide maternity care. The Ontario midwifery course of care funding mechanism provides funding for midwives throughout normal pregnancy, birth and up to six weeks after birth. Other maternity care providers are compensated on a fee-for-service basis, alternate payment plans or through hospital salary.

The AOM stressed that specialist physicians must be compensated for being available to midwives to provide high risk care. The AOM said on-call compensation for obstetricians for emergency midwifery

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\(^73\) Midwives and Interprofessional Care, Association of Ontario Midwives, June 2008, p. 9.
patients is critical to promoting collaborative maternity care. The OMcep Final Report recommended “that physicians of all specialist groups receive fair compensation from the Ontario Health Insurance Plan or an alternative payment mechanism for direct consultations and assessments requested under the scopes of Registered Midwives.” HPRAC understands that the Ministry has addressed this issue through the introduction of hospital on-call (HOCC) payments. Hospital on-call physicians are reimbursed and can also bill a consultation from a midwife referral.

The AOM said that outside a hospital setting, funding barriers turn a simple referral to a paediatrician into a complicated process involving more providers, time and cost than necessary. The referral to the paediatrician must be made by a family physician. If the patient does not have a family physician, she routinely visits a hospital emergency department to access specialist assessment and care, causing a longer delay in patient care, pressure on emergency services and an inefficient allocation of patient time and public money. The AOM says that these funding inefficiencies significantly hinder the provision of timely care and deter the development of multidisciplinary collaborative maternity care.

**Regulation Approval Process**

The CMO and the AOM note that in today’s health care environment, new medications and procedures are a constant, but the government regulation approval process is onerous and deficient. They argue that an alternate mechanism is needed to process regulations that address clinical practice. It is essential to provide timely regulatory responses to emerging best practices and changes in the health care delivery system.

**What the CMO Has Proposed**

The CMO is calling for significant changes in the scope of practice for midwives to fulfil their role as primary maternity care providers and contribute to an interprofessional solution to the sustainability of maternity care in Ontario. Some of the changes apply to routine practice, some are advanced competencies. The CMO says that the proposals will enable Ontario to catch up with other Canadian jurisdictions that they say have moved ahead in terms of midwifery’s role in primary maternity care.

The CMO proposes to amend the profession’s scope of practice statement in the *Midwifery Act, 1991* to read

75 The practice of midwifery is:

i. The assessment and monitoring of the health of a woman and her baby during the normal course of pregnancy, labour and the postpartum period,

ii. The provision of care related to the normal course of pregnancy, labour, and the postpartum period, including counselling, support and advice, and

iii. The management of vaginal deliveries.

In addition, the CMO is seeking access to the following additional authorized acts:

i. Putting an instrument, hand or finger beyond the larynx,

ii. Putting an instrument, hand or finger beyond the anal verge, and

iii. Communicating a diagnosis within the scope of midwifery.

Through access to these proposed authorized acts, the profession would gain the authority to perform a number of procedures, either in routine or extended practice. The routine scope of practice would include:

- Providing pre-conception counselling,
- Managing vaginal deliveries,
- Taking blood samples from fathers or donors,
- Manual removal of the placenta,
- Applying a fetal scalp heart monitor,
- Umbilical vein catheterization,
- Intubation of the newborn,
- Routine perineal tears,
- Administering suppository medications,
- Prescribing and administering oxytocin,
- Prescribing and administering antibiotics for group B streptococcus, mastitis, bacterial vaginosis, urinary tract infections and sexually transmitted infections,
- Administering mumps, measles and rubella vaccine (MMR), and
- Administering varicella immunoglobulin.

The extended scope of practice would include:

- Providing well-woman and well-baby care,
- Vacuum extraction,
- Caesarean section first assist,
- 3rd degree tear repair and provide care related to 4th degree tear repair,
- Scalp pH tests on the foetus,
- Administering childhood vaccinations, and
- Prescribing and administering hormonal contraceptives.

In addition, the CMO is seeking amendments to other legislation to enable midwives to order diagnostic tests, order maternal postpartum ultrasounds and newborn follow-up ultrasounds and direct an ambulance to a facility during a transport, and to change credentialing processes in hospitals.

The CMO said it recognizes that midwives will need further education to provide care under the extended scope components of the proposal. The planning of continuing education and professional development programs for midwives who are currently practicing is underway in collaboration with the AOM, the MEP, the IMPP and other stakeholders. Changes to the curriculum of both the MEP and the IMPP for future midwives are under development with the same group. The CMO submission also noted areas where additional education will be required for midwives to assume the expanded routine scope activities.

**Enabling Interprofessional Maternity Care**

According to the CMO, the proposed changes “…better equip midwives to be full and active members of interprofessional care teams and to operate effectively in interprofessional settings.” The CMO said that:

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76 College of Midwives of Ontario - Document provided to roundtable participants. *Summary Chart (Introduction)* of the Proposed Routine and Extended Scope of Practice for Midwives – August 2008.
Chapter 3 – Review of the Scope of Practice of Midwifery

The proposed changes to midwifery scope will enhance midwives’ capacity to provide care to low risk women and their babies at a level that is similar to a family physician. This will support … primary care maternity providers [having] overlapping competencies, to better meet the needs of the community while working in interprofessional environments. ⁷⁸

The CMO identified a number of enablers required for interprofessional maternity care in Ontario, such as:

- Compensation and funding of maternity care providers,
- Quality improvement programs,
- Interprofessional protocols, policies and guidelines,
- Flexible organizational structures, and
- Patient or caregiver involvement.

The AOM said it recognized the significance of interprofessional collaboration as an important response to the maternity care crisis in Ontario. In Midwives and Interprofessional Care (June 2008), the AOM outlines its support for interprofessional collaboration in the provision of maternity care and recommends solutions to address the barriers to midwives’ integration.

Founded on the MCP² and OMCEP reports, the AOM makes recommendations to facilitate IPC:

- Earmark specific funds to support collaborative maternity care pilot projects in communities that possess both the need and the providers willing to participate to enable thorough evaluation and relevant lessons learned for subsequent initiatives,
- Update the Public Hospitals Act to ensure midwives are guaranteed due process and right of appeal concerning hospital credentialing and representation on committees that determine credentialing,
- Direct local health integration networks (LHINs) to establish consistent guidelines for the integration of midwives into all hospitals that offer maternity care, including guidelines for credentialing and guidelines that ensure midwives are able to work to their fullest scope possible,
- Create funding mechanisms for compensating midwives involved in collaborative models that are equitable both within new maternity care teams and also with midwives working in the current Ontario model. Adequately compensate obstetricians to provide on-call back-up for consultations and referrals from midwives. Physicians must be compensated to be available for high risk transfers of care. Other specialists such as paediatricians or anaesthetists need to be compensated for direct referrals from midwives,
- In conjunction with the Ministry of Training, Colleges and Universities, earmark funds to enhance interprofessional education within the MEP for midwifery students, medical students, residents, nursing students and other health care providers, and
- Fund birth centres for low risk normal births and as model sites of interprofessional education and practice. Interprofessional education is essential to the success of interprofessional care and birth centres offer an ideal environment for providers to learn from, with and about each other.

Chapter 3 – Review of the Scope of Practice of Midwifery

What HPRAC Learned from Research

In addition to reviewing background information and the detailed submission received from the CMO and AOM, HPRAC undertook a review of the published literature, a jurisdictional review of the scope of practice of midwifery outside Ontario, and a jurisprudence review of the scope of practice of midwives nationally. The literature and jurisdictional reviews are posted on HPRAC’s website.

Literature Review

System Needs

Primary maternity care reform in Canada is being driven by several initiatives including the federal government’s Primary Health Care Transition Funds (PHCTF), the Commission on the Future of Health Care in Canada (Romanow Report) and the Multidisciplinary Collaborative Primary Maternity Care Project (funded by PHCTF) – as well as by changing trends in maternity care delivery.

In recent years, the concept of multidisciplinary collaborative primary maternity care has been identified as a means of sustaining and improving maternity care in Canada. The literature discusses concerns about the sustainability of the maternity care system and the need for multi-dimensional and multi-jurisdictional solutions to address the following trends: demographic and societal changes, increases in the number of babies requiring intensive care, human resource shortages among maternity care providers, and regional disparities in the provision of maternity care services. These trends call for new policies at the federal and provincial levels to enhance the capacity of midwifery to make a greater contribution to maternity care and to help solve the practitioner shortage. The key barriers to more rapid progress with multidisciplinary collaborative primary maternity care include regulatory, scope of practice, financial and economic, medico-legal liability, education, awareness and infrastructure issues.

The current challenges restricting full integration and participation of midwives in the delivery of primary maternity care include limited access to care (for example, regional inequalities, human resources shortages, rural-urban inequalities, and inequity in Aboriginal communities), funding mechanisms for both midwives and physicians, the hospital credentialing process and restrictive hospital protocols, the Ontario provincial government process for amending regulations, inflexibility in practice and limits on scope of practice, and obstacles to interprofessional collaboration among maternity care providers, such as lack of a collaborative curriculum and limited interdisciplinary models of care.

Scope of Practice

Ontario was the first Canadian jurisdiction to regulate the profession of midwifery. Ontario’s model of midwifery embodies the principle of informed choice and recognizes the patient as the primary decision-maker throughout the course of care. Accordingly, midwives have a different philosophy of care, a different funding model and a different organizational style than other maternity care providers.

The MCP² Report observes that, unlike other professions, the scope of practice for midwifery in Canada tends to be very descriptive and notes some possible historical and political reasons for how this may

have developed. The regulation of midwifery in Canadian jurisdictions is complex and varies in the level of detail outlined in the legislative and regulatory framework.

Current efforts across Canada and in other jurisdictions focus on addressing shortcomings in the scope of practice to reflect community standards and needs, ensure continued public safety, and further enhance and enable collaboration among providers. Although midwives are seen as an integral part of the primary care system for low risk normal pregnancies and birth, collaborative efforts of physicians and midwives in the community are needed to ensure long-term delivery of high quality care to Canadian women.  

All midwives must determine an acceptable and appropriate scope of practice within which they will provide care that is safe, competent and congruent with standards and models developed by professional associations and regulatory colleges. It is essential for educators and practitioners to find common ground to combine evidence-based theory with evidence-based practice.

If midwifery is to survive and fulfill its commitment to women and families, midwives must support research designed to generate evidence that corroborates the strength of the profession, work with their professional organizations to expand their legal status and role, expand their own scope of practice by continually developing their primary care knowledge and skills, and undertake research studies in such key areas as the ongoing evaluation of home births and additional work to define midwifery as distinct from medicine where both coexist within a collaborative system.

Patient Safety and Outcomes

Models of care are significantly different in obstetric-led birthing units than in midwife-led units. In the former there is greater likelihood of intrapartum intervention, need for analgesia, and assisted or operative delivery. Some evidence supports comparable clinical outcomes, safe practice and high rates of satisfaction among midwifery patients.

In particular, findings from published studies include:

- Mothers in midwife-led units spent shorter times in labour in the unit, received less analgesia, had fewer interventions and were more likely to have a normal delivery than women in obstetric-led units.  
- Consistency in the generally favourable results of midwives’ care in maternal and neonatal outcomes, both over time and among diverse population groups. These outcomes are also favourable when compared to various reference groups such as birth centre births, planned hospital births and vital statistics.

Chapter 3 – Review of the Scope of Practice of Midwifery

- Similar outcomes arising from a comparison of home births with hospital births attended by a midwife. There was no increased maternal or neonatal risk associated with planned home birth under the care of a regulated midwife.\(^\text{87}\)
- Women giving birth at home attended by a midwife having fewer procedures during labour than those giving birth in a hospital attended by a physician. They were less likely to have epidural analgesia, be induced, have their labour augmented with oxytocin or prostaglandins, or have an episiotomy.\(^\text{88}\)
- Midwifery clients reporting greater satisfaction and a more positive attitude toward their childbirth experience than women in the care of physicians.\(^\text{89}\)

Despite commitments to evidence-based practice and adoption of common professional practice guidelines, practice patterns among midwives vary significantly across settings. The integration of midwifery into Canadian hospitals has been inconsistent.

**Jurisdictional Review**

In Canada, five provinces and one territory outside Ontario currently regulate midwives. These are British Columbia, Alberta, Saskatchewan, Manitoba, Quebec and the Northwest Territories. Nova Scotia and New Brunswick have passed statutes governing midwifery but these have not yet been implemented. The College of Midwives of British Columbia currently has policy proposals under consideration by the Minister of Health Services. The proposals are far reaching and would significantly change the scope of practice of midwifery in British Columbia; however, they have yet to be approved by the Minister.

**Legislation**

In the six jurisdictions that regulate midwives, the scope of practice of midwifery is specified in statutes or regulations to varying levels of detail. The legislation in each case authorizes midwives to perform certain acts that in Ontario would be considered controlled acts, although none of the other jurisdictions uses that term.

Each jurisdiction grants a general authority to manage normal or spontaneous labour and vaginal delivery, with those terms used to exclude caesarean sections and deliveries with serious complications. Other controlled acts are typically authorized in regulations and fall into three main categories:
- performing minor surgical or invasive procedures,
- prescribing and administering drugs, and
- ordering, conducting and interpreting diagnostic tests.

Surgical and invasive procedures that are uniformly authorized include the performance of amniotomies and episiotomies, and the repair of episiotomies and other tears, with authority for repairs generally limited to 3\(^\text{rd}\) degree or lesser tears. Repairs of the urethra and sphincter are generally not permitted.


Authority with respect to prescription drugs and testing varies more widely. The authority is often limited in one or more respects, such as requiring that drugs or tests be prescribed for women or newborns only, or for certain limited purposes, or only under the direction of a physician.

Policies Prescribed by Regulatory Bodies

The regulatory body in each jurisdiction typically establishes a number of additional policies that govern midwifery practice. These policies are commonly labelled “standards”, “guidelines” and especially “competencies.” The policies elaborate on the basic authority established by statute and regulation and, in so doing, may clarify, expand or limit the ability of midwives to perform the authorized acts.

Regulatory bodies use several different mechanisms to shape the statutory authority granted to midwives:

- **Inferred Authority:** A regulatory body may interpret the broad language of its governing legislation and find authority for specific invasive procedures or other acts that are not otherwise expressly authorized. Broad legislative authority to care for, monitor and assess clients invites regulatory bodies to authorize specific acts in their policies to achieve those ends, such as the application of foetal scalp electrodes or the insertion of umbilical vein catheters.

- **Advanced Competencies:** Several jurisdictions use their policies to identify certain acts that may be performed only by midwives who possess some form of advanced competency. British Columbia, Saskatchewan, Manitoba and the Northwest Territories all have policies of this nature. These advanced acts are often expressly authorized in legislation, and the policies thus serve to limit the authority of midwives. Alberta does not take this approach but the regulatory body uses guidelines to restrict the authority of midwives to prescribe certain drugs that are otherwise authorized under provincial regulations.

- **Consultation Requirements:** Several jurisdictions have established detailed guidelines that require midwives to either consult with or transfer care to a physician when certain clinical conditions arise. These guidelines are often elaborations on broad statutory direction for midwives to consult when complications arise but may also be established in the absence of such direction.

**Shaping Sensitive Areas of Practice**

Regulatory bodies are particularly likely to use the above mechanisms, often in combination, to shape the scope of midwifery practice in two related and sensitive areas of practice.

**Induction and Augmentation of Labour**

The governing legislation in each jurisdiction requires that the deliveries “conducted” or “managed” by midwives be “spontaneous.” In no case is the term “spontaneous” defined in the legislation. The legislation governing midwives also uniformly grants midwives the authority to perform amniotomies and episiotomies.

The various regulatory bodies manage this ambiguity by clarifying and restricting the authority of midwives to augment and induce labour by both pharmacological and non-pharmacological means. In Manitoba, for example, induction and augmentation of labour requires additional competency standing and approval by the regulatory body. Saskatchewan imposes similar requirements. The same is true for

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90 In British Columbia the College of Midwives has proposed regulatory changes that would introduce “Specialized Practice” provisions into the provincial Midwives Regulation.
vacuum extraction in Saskatchewan and the Northwest Territories. In British Columbia, oxytocin may be prescribed only by a physician. In addition, guidelines for consultation with a physician generally require it for such indicators as abnormal labour pattern and failure to progress in active labour.

Emergency Measures

The legislation governing midwifery practice in emergency situations is often very general, or the legislation may even be silent with respect to emergencies. As a result, regulatory bodies use their policies to provide more detailed direction to midwives facing emergency situations. In most cases this direction includes substantial restrictions.

For example, the legislation in Manitoba is silent with respect to emergency practices in general and manual removal of the placenta in particular. However, the regulatory body has included general emergency provisions in its policies and requires mandatory consultation with a physician in cases of retained placenta. It has also issued an additional guideline for the Emergency Manual Removal of the Placenta.

The statute in the Northwest Territories authorizes “emergency measures when necessary.” The policies of the regulatory body elaborate on this authority and approve “vacuum-assisted birth”, “manual evacuation of the uterus” and “assist with caesarean section”, for midwives who have received advanced in-service training. These procedures must also be performed in accordance with the guidelines of the national Neonatal Resuscitation Program.

As part of the jurisdictional review, HPRAC summarized the prescribing, laboratory and diagnostic testing authority in the other six jurisdictions in Canada that regulate midwifery. This part of the jurisdictional review revealed similar variations among the other six Canadian jurisdictions with respect to a midwife’s independent authorization to prescribe and administer drugs, and order screening and diagnostic tests.

Perspectives from the Consultations

HPRAC’s consultation program was designed to gain additional information, perspectives, and understanding of issues, benefits and risks associated with changing the scope of practice of midwives in Ontario. As part of the consultations, HPRAC held broad local health provider roundtables in Ottawa, Thunder Bay, Sudbury, Windsor and Hamilton, met with other regulators and professional associations in Toronto, and conducted a number of key informant interviews. A separate meeting was also arranged with key educators. In addition, at the beginning of the consultation process an initial meeting was held with the CMO and AOM to review the submission.

The CMO’s submission, developed in collaboration with the AOM, was the result of a number of influences and initiatives:

- consultation with members through forum meetings, formal surveys and routine interaction with CMO staff and council members,
- the experience gained during 15 years of self-regulation,
- the collective knowledge of the CMO’s council members, both public and professional,

Chapter 3 – Review of the Scope of Practice of Midwifery

- emerging best practices in interdisciplinary maternity care,
- the experience of other Canadian jurisdictions that regulated after Ontario, and
- a number of comprehensive, focused studies of maternity care and the role of the midwife in that care.

HPRAC received 29 written responses to the review of the scope of practice for midwifery. A number of letters of support were received from individual midwives, midwifery practice groups and midwifery educators. In addition, HPRAC received submissions from other health care providers and organizations. Some indicated their support, others raised issues and concerns, and some did both with respect to the proposals. HPRAC has considered these responses in its analysis and recommendations. All of the responses are available on HPRAC’s website.

Information from the Roundtables

The key points emerging from HPRAC’s roundtable consultations on the midwifery scope of practice referral are summarized under three main categories: System Needs, Scope of Practice and Competency. At each roundtable, a representative from the CMO and the AOM provided a brief introductory presentation outlining the request made by the profession in response to the Minister’s request for advice.

System Needs

One of the clear messages from midwives participating in the roundtables was that the practice faces many structural barriers in Ontario. Midwives often spoke about a number of system difficulties they encounter. They reported challenges in dealing with other health care professionals who do not accept the legitimacy of their role in birthing and in hospitals. Midwives said that the hospital credentialing process was seen by many to be cumbersome, unfair and inefficient. There are hospitals in Ontario where midwives are not allowed to practice and this limits their ability to take stress off the maternity system. Midwives also said that while their working relationships in some hospitals are positive, in others they do not feel welcome. Currently the Ontario Hospital Association and the CMO are working on a new midwifery toolkit to integrate midwives into a hospital that will be available to all hospitals in the province.

A number of midwives told of some of the difficulties in developing collaborative maternity practice models because of different funding models for different professions and within professions. Midwives practice under a provincial program that determines where they can work and how they are compensated. Several midwives stated that this model creates barriers to more effective collaborative care.

Midwives at different roundtables spoke of the MORE\(^{OB}\) program, which they said is an innovative way to develop more collaborative care settings. Midwives told HPRAC that there is a need to provide other opportunities for a broader variety of pilot projects or models similar to this initiative.

WHAT HPRAC HEARD ABOUT…SYSTEM NEEDS

“During pregnancy the coordination of care between family physicians and the professionals who provide prenatal care and delivery is often very poor now. The midwifery scope prevents midwives from consulting with family physicians except for non-obstetrical issues. Many physicians work in shared-care models and a shared-care model for maternity care is what we should consider.”

Lee Donohue, Family Physician, Family Health Group, Ottawa, Ontario

Interprofessional Collaboration Phase II

September 2008
“We need to loosen the outside walls of the regulatory structure to allow more room for the College and its members to be creative in communities. You need to work in groups to provide primary maternity care on call 24 hours a day, seven days a week, to maintain your health, sanity and good care for your clients.”

Robin Kilpatrick, Deputy Registrar, College of Midwives of Ontario

“Integration in an already over-taxed, under-served system is challenging. Discharging people without a family physician is a major stressor in our practice. For simple health concerns, in the absence of full scope health care providers, we must use walk-in clinic resources for treatment of a variety of ailments common in pregnancy, such as urinary tract infections. We also have nursing shortages and therefore we spend time waiting for nurses to be available when our clients require intrapartum care beyond our scope or privileges.”

Sky River Dasey, Midwife
St. Jacobs, Ontario

“We need to properly fund obstetricians to be on-call, not under the fee-for-service system, which does not work well for collaborative care. If we are to look at having freestanding birth centres and more collaboration amongst professionals, we need to look at different funding models.”

Anne Wilson, Midwife
Burlington, Ontario

Scope of Practice

Many of the midwives raised issues about their scope of practice and the need to expand their access to additional controlled acts. The roundtables involved midwives from around the province working in a range of practice settings. They said that in some hospitals, they are not allowed to practice to the full extent of their individual scope of practice. The limitations were usually placed on the management of oxytocin induction or augmentation and on the management of epidural analgesia maintenance, and were established in hospital policies, through delegation protocols or medical directives.

Representatives from the CMO and the OAM underlined at the roundtables that the purpose of requesting an expanded scope of practice was to bring Ontario to the level of several other provinces and to lay a basis for future growth and development. Individual midwives said that greater access to ordering various diagnostic tests would be of great help to the effectiveness of their work and to better patient care.

**WHAT HPRAC HEARD ABOUT…SCOPE OF PRACTICE**

“With an extended scope of practice, it might be more likely that we can work on our own extended scope because we have that extra skill set. We have more to offer to the community for primary health care provision and care during labour and delivery. We can work with the assistance of nurses and in Hearst there is a midwife working closely with the family physician.”

Kirsty Bourret, Midwife
Sudbury, Ontario
“I once had to convince a family physician that a patient needed to be given antibiotics for asymptomatic Group B strep urinary tract infection. The physician, who did not practice obstetrical care, refused despite the fact that the woman’s previous child had developed Group B meningitis.”

Lucia D’Amore, Midwife
Burlington, Ontario

Competency

In addition to the roundtables, HPRAC held a discussion with a number of midwifery educators to learn how current programs covered the request for expanded scope of practice. The educators felt that graduates today were being taught many of the skills that the expanded scope of practice would require. HPRAC was told that continuing education programs and more placement settings would be needed to provide midwives with the experience to handle advanced procedures.

Midwifery educators informed HPRAC that the educational curriculum for the MEP in Ontario is changing to address the need for increased interprofessional collaborative care. One of the key rationales for updating the midwifery curriculum is to “address [the] Maternity Care Human Resource shortages by preparation for special needs populations and more emphasis on interdisciplinary practices.” Moreover, the MEP aims to ensure that all graduates are competent in care management areas that are sometimes restricted by local hospital rules.

College spokespeople also said that they had work to do in determining more clearly what would be expected from individual midwives through standards of practice.

WHAT HPRAC HEARD ABOUT…COMPETENCY

“It is a challenge to keep someone’s competency up for something that isn’t routine care, including emergency skills. We may not have an undiagnosed breech birth for ten years, but every year we must practice how to deliver a breech baby.”

Susan James, Midwife and Program Director, Midwifery Education Program
Laurentian University, Sudbury, Ontario

An Enabling Regulatory Framework

While the RHPA was a momentous step forward in regulating health professions when it was passed in 1991 – so much so that other jurisdictions are still trying to emulate the model – it was designed to be living legislation. HPRAC contends that the regulatory framework must constantly change to meet the requirements of the 21st Century.

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92 Midwifery Program Curriculum Changes Overview. Provided to HPRAC August 8, 2008.
93 As recommended by the Coroner in the Verdict Explanation for the Inquest Into the Death of Eoin Stalker, 2006.
HPRAC is therefore proposing a new approach to the regulation of midwifery: an enabling regulatory framework. HPRAC’s approach builds on the principles of the \textit{RHPA}. It recommends ways to make the regulatory framework more flexible and adaptable, while strengthening the accountability of the regulatory colleges and their members.

An enabling regulatory framework couples a broader scope of practice for a profession, contained in legislation and regulations, with appropriate standards, limitations and conditions to be established by the regulatory College for the performance of authorized acts. The standards of practice would be recognized in statute, giving the College the clear legal authority to mandate compliance by members. The College would be required to involve other professions in the development of these standards, nurturing interprofessional collaboration.

The proposed approach allows for the evolution of midwifery practice over time – consistent with, “changes in practice environments, advances in technology and other emerging issues” – through standards, limitations and conditions adopted by the CMO without recourse to changes in legislation or regulation\textsuperscript{94}. This direction is balanced with an enhanced role for the regulator (the CMO) to more actively regulate the profession in the public interest and to ensure that an appropriate accountability framework is in place to protect the public from the risk of harm. Specifically, under the enabling model the CMO will have to address issues of continuing competence and the involvement of other professions in the development of standards, limits and conditions. HPRAC concluded that the model provides a measured approach with the appropriate checks and balances to protect the public.

A fundamental difference between the proposed approach and the status quo is that the contemplated standards, limitations and conditions, with statutory force, are to be established by the CMO independent of the regulation-making process.\textsuperscript{95} Such a role for the CMO is consistent with its current and future objects under the \textit{RHPA}.\textsuperscript{96}

**Interprofessional Collaboration and the Development of Standards of Practice and Professional Practice Guidelines**

The Minister has requested HPRAC to:

\textsuperscript{94} HPRAC has previously commented on the problems experienced by health regulatory colleges under the \textit{RHPA}, with the regulation-making process in Ontario. See: HPRAC, \textit{Regulation of Health Professions in Ontario: New Directions} (April 2006), pp.62-71.

\textsuperscript{95} See Health Professions Code, s.95, which provides:

\textit{“(1) Subject to the approval of the Lieutenant Governor in Council and with prior review of the Minister, the Council may make regulations,}

(a) prescribing classes of certificates of registration and imposing terms, conditions and limitations on the certificates of registration of a class; …

(n) prescribing the standards of practice of the profession and prohibiting members from acting beyond the scope of practice of the profession in the course of practicing the profession; …

\textsuperscript{96} See: \textit{RHPA}, s.3(1) clauses 3, 4, 7 and 8. Forthcoming changes to the objects of the College, to take effect June 4, 2009, (or some other date established by proclamation) will re-cast these current objects as follows:

4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members. [Replacing the current clause 4.]

8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public. [New.]

9. To promote inter-professional collaboration with other health profession colleges. [New.]

10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues. [New.]
recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession.

The Minister has also asked HPRAC to:

- take into account, when controlled acts are shared, of public expectations for high quality services no matter which health profession is responsible for delivering care or treatment.

Standards of Practice

The term “standards” or “standards of practice” is defined differently by various colleges and other professional entities. For the purposes of this report and specifically in respect of the scope of practice review, HPRAC refers to standards of practice as the rules, requirements, responsibilities and conditions that describe the CMO’s expectations for midwifery in Ontario to provide high quality, ethical and safe care to patients. At a minimum, a health profession’s standards of practice should include requirements concerning education, continuing competence, quality assurance, record-keeping, conflict of interest, mandatory discussion, consultation and transfer of care.

HPRAC’s recommended approach in respect of an expanded scope of practice is set out below:

In the Midwifery Act, 1991:

- provide authority for the performance of new authorized act(s),
- amend the scope of practice statement, if necessary, to address the parameters of the new authorized act(s),
- require members to perform all new authorized acts in accordance with any requirements prescribed in the regulations,
- provide for any other additional requirements for authorized acts that can be pre-determined and are non-exemptible,
- require members to identify the limits of their educational preparation and competencies, and to resolve situations beyond their expertise by consulting with or referring patients to other health care professionals, and
- include a provision enabling Council to make regulations concerning requirements for the performance of new authorized act(s).

In the regulations made under the Midwifery Act, 1991:

- where appropriate, ensure that members provide satisfactory evidence of successful completion of a post-graduate program that meets approved criteria when they wish to engage in a new authorized act(s),
- require members to perform all new authorized acts in accordance with any standards of practice established by the CMO from time to time,
- provide for any clarification of authority for the performance of new authorized act(s) as necessary,
Chapter 3 – Review of the Scope of Practice of Midwifery

- require the CMO to develop standards of practice for the new authorized acts through a process of interprofessional collaboration with other colleges, individuals and entities, and
- require the CMO to post on its website the standards of practice and, in some cases, those members who are authorized to perform a new authorized act.

Interprofessional Development of Standards, Limitations and Conditions for Midwifery Practice

A key element of HPRAC’s approach is the creation of a new Midwifery Standards Committee. This step would allow for full review and consultation on the matters to be included in standards, limitations and conditions, while providing flexibility to respond to the evolution of midwifery practice, as these matters would not have to be addressed in regulation.

The rationale for this proposal is to establish a permanent forum where legitimate concerns about the standards, limitations and conditions for midwives’ performance of controlled acts can be meaningfully discussed and resolved among the health professions that will be engaged in collaborative practice with midwives. Through these discussions best practices can also be established. The current legislative framework imposes no obligation upon the CMO to involve representatives of other relevant professions in the development of standards, limitations and conditions.

HPRAC acknowledges the inherent difficulty in legislating interprofessional collaboration among health professionals, but is convinced that the proposed model strikes a reasonable balance – requiring the CMO to develop standards, limitations and conditions with input from persons with a range of relevant expertise, while at the same time not providing any one participant in the process with a power of veto. The self-regulatory role and responsibilities of the CMO are respected by placing responsibility for making appointments to the Midwifery Standards Committee with the CMO. HPRAC is further recommending that there be representation from the midwifery education community.

In following this approach, the standards of practice do not and would not include professional practice guidelines.

Professional Practice Guidelines

The colleges refer to professional practice guidelines in many ways. Some use this term, while others have employed the terms guidelines, clinical practice guidelines or other titles. Professional practice guidelines set out best practices for clinical care.

It is not within HPRAC’s mandate to develop professional practice guidelines. This falls within the mandate, the competence and the responsibility of the profession.

What HPRAC proposes to do, however, is to consider whether and what kind of an interprofessional process should be followed by the regulated health professions when they develop professional practice guidelines, particularly where one or more professions share the same or similar authorized act.

HPRAC will engage in consultation on and analysis of this issue as the second phase of HPRAC’s interprofessional collaboration project continues, with recommendations to the Minister to follow in 2009.
HPRAC’s Observations

In addition to conducting the literature and jurisdictional reviews and the consultation process, HPRAC has made a number of observations within its review of the scope of practice for midwifery.

One of the key themes identified in the review is the number of barriers faced by practising midwives in Ontario. While some of the barriers may result from the current midwifery scope of practice, HPRAC sees the key barriers as matters of structure and process. These include: care team models, Ministry program funding, and compensation models. HPRAC suggests that the government needs to be more proactive in resolving these issues, since midwifery is a managed program of the Ministry.

In light of the barriers facing midwifery, the CMO has requested significant changes to the current scope of practice, including the establishment of two separate classes of registration -- routine and extended. Taken as a whole, the requests would result in a fundamental shift in the scope of practice of midwifery in Ontario.

A key rationale guiding the CMO’s submission is its view that Ontario, as the first jurisdiction to regulate midwifery, now lags behind other Canadian jurisdictions that have regulated the profession since 1991. HPRAC undertook a jurisdictional review of all Canadian jurisdictions that regulate midwifery. The various legislative and regulatory frameworks for midwifery across Canada are complex and vary significantly. In most cases, the full scope of practice for midwives is not articulated in legislation or regulations. In some cases, the legislation or regulations may be silent and, as a result, the authority may be inferred, while in other circumstances the details are contained in a regulatory college guideline or standard of practice. Overall, HPRAC’s research does not support the conclusion that Ontario has fallen behind other Canadian jurisdictions in the regulation of midwifery.

In both the consultations and in the written submissions, stakeholders raised concerns about midwives’ level of education and clinical training in light of the expanded scope of practice requests. One recurring issue is the gap in interprofessional clinical training to support some of the more complex and highly technical procedures, as well as the need for steady exposure to these procedures in order to maintain competency. 97

Midwifery has strong cultural and political roots, including a unique philosophy of care and a commitment to a woman’s choice of place of birth. 98 Ontario has a unique model of care for the autonomous practice of midwifery. It was the first province to regulate midwifery in Canada and many elements of Ontario’s approach were emulated in other provinces. Like the other six jurisdictions in Canada that now regulate midwifery, the scope of practice in Ontario is based on a combination of specific authorization in statute, as well as additional requirements for practice established in regulations and in practice guidelines.

Over the past 15 years, the College has established a number of guidelines that, together with the legislative and regulatory framework, create the scope of practice for the profession. With the evolution of the profession and the recognition of a primary maternity care crisis, the College has acknowledged that some of the requirements in the guidelines – including the requirement for two midwives to attend every birth – should be reviewed. The College submission states that this requirement has been identified

97 Informant interview, Dr. André Lalonde, Executive Vice-President, Society of Obstetricians and Gynaecologists of Canada. August 12, 2008. Also see Submission from the OCFP to HPRAC in Respect to The College of Midwives of Ontario Scope of Practice Review. August 15, 2008. p. 8.
by midwives as an impediment to the provision of more primary care by midwives and as a possible deterrent to forming more positive relationships with hospital personnel, particularly nurses. 99

The College cites the following policies and guidelines that must be addressed as part of the evolution of the profession and in response to health human resources challenges:

There are also a number of scope-of-practice issues that can be dealt with at the CMO level, rather than through a regulatory amendment process…. These policies will be examined within the framework of our guiding principles of informed choice, choice of birthplace, and continuity of care to continue to support the philosophy of birth as a normal physiologic process.

This review also considers the current context of health care (the appropriate and increasing emphasis on interprofessional collaboration, continued and growing economical constraints on the system, the shifting demographics of the province’s population). Specifically, the CMO will review:

• the requirement that there be 2 midwives at every birth,
• the current active practice requirements,
• the continuity of care requirements,
• the guidelines for certification to work outside the primary scope of practice,
• the CMO standard Indications for Mandatory Discussion, Consultation, and Transfer of Care. 100

Currently, the College controls the types of interprofessional practice arrangements in which midwives may engage by requiring College approval for any departure from these rules. This limits how midwives can associate with other professions in practice. Notwithstanding this requirement, the College advised HPRAC that just over half of all midwifery practices have a Temporary Alternate Practice Arrangement, though not all practices use it regularly. 101 In addition, midwives must perform a minimum requirement of ten home births upon registration with the CMO. This condition, as an active practice requirement, is contained in regulations made under the Midwifery Act, 1991. 102

During the consultations, HPRAC heard about both internal and external barriers impeding the full integration of midwifery across the province.

HPRAC acknowledges that the CMO’s active practice policies and guidelines may have been appropriate when the practice of midwifery was first regulated, but welcomes the CMO’s initiative to review its policies and agrees that this process should occur in the context of the evolution of the profession and the challenges facing maternity care today. In its discussions on the external barriers facing the practice of midwifery in Ontario, HPRAC heard that some of the CMO’s policies have inadvertently reinforced the reticence of other health regulated professions about midwifery.

HPRAC found that the CMO’s Indications document, setting out requirements for transfer of care, has been instrumental in helping to eliminate barriers that prevent midwives from practising to their full scope. The College advises that this document has the support of the Ontario Hospital Association (OHA). 103

100 The College of Midwives of Ontario Submission to HPRAC. p. 24.
Chapter 3 – Review of the Scope of Practice of Midwifery

The College and the OHA are working together to update the 1994 document, *The Integration of Midwifery Services Into Hospital*, and to promote the full integration of the *Standards* document for all hospitals across Ontario.\(^{104}\) HPRAC sees this document as key to addressing some of the system barriers facing midwives.

HPRAC agrees that there is a crisis in primary maternity care in Canada and that there is a critical role for midwives in alleviating the pressure on the maternity care system. Based on statistical data concerning the number of obstetricians, family physicians and midwives and the number of births each is responsible for attending each year, midwives clearly have an important part to play in the delivery of low risk, normal births.\(^ {105}\) The leading Canadian reports do not recommend that the scope of practice for primary maternity health care providers be expanded or reviewed, but rather that the limited resources available to deliver primary maternity care should be maximized to ensure access to safe maternity care.\(^ {106}\) The reports and implementation activities that have followed provide a unique opportunity for interprofessional collaborative care. HPRAC endorses this direction and has grounded its analysis and recommendations on this opinion.

HPRAC is encouraged by a number of enablers and opportunities. Many of these were identified by the AOM in its June 2008 Interprofessional Care paper. As part of its approach to the review of the scope of practice of midwifery and the need to address the structural barriers, HPRAC will refer to some of the key opportunities and enablers throughout its recommendations in this report, including:

- The MORE\(^ {108}\) Program,
- The MCP\(^2\) Interprofessional Care Pilot models, and
- Integrated Birthing Centres.

**HPRAC’s Approach**

For the purposes of analysis, HPRAC has grouped the requests by the CMO into three categories:

- Clarity or additional authority for specific activities and procedures and authority for new controlled acts – including communicating a diagnosis,
- Clarity or additional authority for procedures that are either considered high risk or done in emergency situations,\(^ {107}\) and
- Amendments to other legislation to authorize the ordering of additional laboratory tests and diagnostics, the prescribing of additional medications including antibiotics, and other activities.

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\(^{104}\) Ibid.
\(^{105}\) See *A National Birthing Initiative for Canada*. January 2008.
\(^{106}\) Ibid., January 2008, p. 10.
\(^{107}\) The College of Midwives of Ontario. Proposed Scope of Practice Changes – summary chart. August 2008; Informant interview, Dr. Andre Lalonde, Executive Vice-President of the Society of Obstetricians and Gynaecologists of Canada. August 12, 2008; Submission from the OCFP to HPRAC in Respect to The College of Midwives of Ontario Scope of Practice Review. August 15, 2008.
Clarity, Authorization for Specific Activities and Procedures, and New Controlled Acts

HPRAC has included the following requests in this category:

1. To amend the existing controlled act of taking blood samples from newborns by skin pricking or from women from veins or by skin pricking to allow taking blood samples from newborns by skin pricking or from women or fathers or donors from veins or by skin pricking.

2. To clarify the current authorized act of putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period to allow midwives to apply a foetal scalp heart monitor.

3. To authorize putting an instrument, hand or finger beyond the anal verge for the purpose of the administration of suppository medications.

4. To clarify an existing authorized act to authorize midwives to assist at caesarean sections.

*To amend the existing controlled act of taking blood samples from newborns by skin pricking or from women from veins or by skin pricking*

The CMO has requested authorization to allow taking blood from newborns by skin pricking or from women or fathers or donors from veins or by skin pricking. The CMO said that it is important for a midwife to be aware of the blood type of the father or donor as a diagnostic tool. This information could potentially influence certain aspects of clinical care needed by a pregnant woman or the baby. The CMO views it as a preventative measure and a means to promote the health of the mother and the unborn child.

In the Northwest Territories, midwives are specifically authorized to test for “Immunohematology: ABO blood group and Rhesus for mother, father and baby”. In Saskatchewan, testing is authorized without respect to gender or age, so long as it is “within the scope of the practice of midwifery.” In Manitoba, blood tests are authorized without respect to age or gender; however, the College reports that Manitoba midwives routinely take blood samples of fathers. ¹⁰⁸

HPRAC finds that authorizing midwives to take blood samples from fathers or donors does not increase the risk of harm to the mother or foetus. Midwives are currently educated, trained and authorized to perform this controlled act and routinely take blood samples from women receiving midwifery care. There may be additional value, for example, in allowing midwives to test fathers or donors for ABO blood group and Rhesus, HIV or sickle cell disease. HPRAC sees a potential for risk of harm if the blood test results indicate a problem or abnormality and those results are not shared with an appropriate health professional. The Indications document on consultations and referrals should be enhanced to include blood tests and other diagnostics.

As the purpose of the test is to protect, promote and ensure the health of the mother and the baby, HPRAC agrees that this is a useful test for midwives to order.

**Recommendation:**

1. That midwives be authorized to take blood samples from fathers and donors from veins or by skin pricking.

To clarify the authorized act of putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period to allow midwives to apply a foetal scalp heart monitor

The CMO requested that section 4(4) of the Midwifery Act, 1991 be clarified to ensure the statute is interpreted to allow midwives to perform this procedure. This is one of several requests by the CMO to clarify the interpretation of the Midwifery Act, 1991. The procedure involves attaching a fetal heart monitor onto the foetus’ scalp by inserting a hand or finger beyond the labia majora.

The CMO is seeking clarification of what it describes as a routine procedure during labour. The CMO further maintains that midwives are trained to perform the task, and that the interpretation of the act should reflect this.

On the basis of the information received in its consultation process, HPRAC has concluded that this procedure, in and of itself, is not a high risk procedure for the mother or baby during a vaginal delivery. According to the Ontario College of Family Physicians, although this may be a valuable activity for midwives to undertake, it is one that may signal the need for an automatic referral to another health care professional. The SOGC excludes continuous electronic foetal heart monitoring for low risk birth from its definition of normal birth.

Other Canadian jurisdictions either authorize or infer authority for midwives to perform this act. In Saskatchewan applying a foetal scalp monitor is authorized under an advanced competency and in Manitoba it is inferred under advanced competency. In Alberta, British Columbia and the Northwest Territories, it is an inferred authority under the general competencies, but nothing in the statutes or regulations expressly authorizes performing the act.

HPRAC’s recommendation does not require changes to legislation or regulations. It reinforces the need for regulatory rigour as a mechanism to address structural barriers that midwives have identified in their practice environment. The CMO should develop detailed standards of practice with limitations and conditions, to specify the procedures included in the authorized act, clinical protocols, referral requirements and the minimum level of education and clinical training required to perform each of the procedures.

Recommendation:

2. That the CMO develop standards, limitations and conditions in conjunction with other health professions to establish when and under what circumstances a midwife is authorized to undertake the controlled act of putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period.

3. That the Indications [Indications for Mandatory Discussion, Consultation and Transfer of Care] document be amended to specifically address how the use of a foetal scalp heart monitor must be treated in the context of consultation and referral.

109 See Submission from the Ontario College of Family Physicians (OCFP) to the Health Professions Regulatory Advisory Council (HPRAC) in Respect to The College of Midwives of Ontario Scope of Practice Review. August 15, 2008.
110 Submission from the OCFP to HPRAC in Respect to the College of Midwives of Ontario Scope of Practice Review. August 15, 2008. p.7
Chapter 3 – Review of the Scope of Practice of Midwifery

Authorization for the controlled act of putting an instrument, hand or finger beyond the anal verge for the purpose of the administration of suppository medications

The CMO has requested limited authorization for the controlled act of putting an instrument, hand or finger beyond the anal verge for two specific purposes: (a) routine perineal repair procedures and (b) the administration of suppository medications. This section addresses only the specific purpose of the administration of suppository medications.

The CMO indicates that performing this act is a routine part of maternity care provision. The activity itself does not pose additional risk to the patient, and suppository medications could be administered safely to a patient by a midwife with entry level training and education.

Given midwives’ specialized education and training to deliver normal vaginal births, including performing procedures such as episiotomies, HPRAC finds that the administration of suppositories by midwives carries minimal risk to the patient. However, since midwives have not had access to the controlled act of putting an instrument, hand or finger beyond the anal verge, midwifery’s current scope of practice excludes any activity around the anal verge. The CMO did not specify circumstances that would necessitate this activity nor the type of medication that would be administered in this manner.

The jurisdictional review reveals that this activity is either authorized, or not expressly limited, in the other jurisdictions in Canada. HPRAC recognizes that patient care could be enhanced if a midwife did not have to wait for a physician or nurse to administer the medication in a hospital, or had the authority to administer the medication in a home birth. The CMO will necessarily develop detailed standards of practice for this procedure.

Recommendation:

4. That midwives be given the authority to put an instrument, hand or finger beyond the anal verge for the purpose of administering suppository medications.

Clarify the existing controlled act of managing labour and conducting spontaneous normal vaginal deliveries to authorize midwives to assist at caesarean sections

This request presents an opportunity to strengthen interprofessional communication and collaboration at both the regulatory and practice levels.

The CMO has requested clarification of the existing controlled act of managing labour and conducting spontaneous normal vaginal deliveries to authorize midwives to assist at caesarean sections. The CMO contends that the clarification would enable midwives to help address the health human resources shortage in primary care across the province, as well as to provide midwives with the ability to provide continuous care according to patient needs. The CMO is not requesting that midwives be granted the independent authority to undertake caesarean sections as this would be beyond their competencies and outside the profession’s philosophy of care.

Chapter 3 – Review of the Scope of Practice of Midwifery

The CMO has an existing *Guideline for Midwife Certification for Surgical First Assist for Caesarean Section*\(^{113}\) which outlines the training and education required for midwives to assist physicians in delivering caesarean section births. It was unclear to HPRAC why additional clarification of an existing competency would be necessary when the CMO is not seeking independent authorization to perform this procedure, and has already established a guideline specifically related to caesarean assists.

While some jurisdictions make reference to caesarean section assists in college competencies, only the Northwest Territories expressly authorizes the activity, under emergency measures, with advanced training and authority. British Columbia is considering granting express authority to midwives to assist in caesarean sections provided they have completed additional certification.\(^{114}\)

The Ontario College of Family Physicians (OCFP) agrees that appropriately trained midwives should be able to assist in a caesarean section birth. HPRAC sees the CMO’s guideline and the OCFP’s statements as indicative of the role that midwives can play in primary maternity care, and concludes that there is no need for amendments to the *Midwifery Act, 1991* or regulations made under the act to allow trained midwives to undertake this activity. HPRAC concludes that if hospital policies prevent midwifery assistance at caesarian births, they should be reconsidered so that midwives are included as an integral part of an interprofessional primary maternity care team. This should be a subject of discussion with the Ontario Hospital Association.

**Recommendation:**

5. That no changes are required to the *Midwifery Act, 1991*, or regulations made under that Act, to authorize midwives to assist at caesarian section births.

**Requests Related to High Risk Births and Emergency Situations**

HPRAC has grouped a number of the CMO’s requests relating to high risk births and emergency situations.

From its review of current research, including the most recent Canadian studies on the primary maternity care crisis,\(^{115}\) along with information gathered throughout its consultations, HPRAC agrees that there is a crisis in primary maternity care in Canada. The crisis is directly linked to the shortage of health human resources, specifically the shortage of obstetricians and gynecologists who provide obstetrical care and the decreasing number of family physicians willing to attend births.\(^{116}\) Midwives can play a valuable role in filling the gap in primary maternity care services; however, HPRAC sees the appropriate role for midwives as one that accords with their education and training in delivering low risk, normal births.

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Obstetricians and gynecologists’ skills will then be appropriately allocated to care for high risk, complicated pregnancies and births.\footnote{The World Health Organization deems that 70-80 percent of all births are considered to be normal or low risk. Currently, obstetricians are attending over 80 percent of all births. See above sections: A Growing Shortage of Maternity Care Providers and Normal Birth.}

The CMO has reaffirmed its vision of the role that midwives play, stating that:

The CMO is not proposing that midwives provide care through either the expanded routine or the extended scope to women with high risk pregnancies. Midwives will continue to provide care for normal, low risk women and newborns and continue to transfer care where needed as regulated by the College. The intent of the submission is to:

- support the provision of full primary care to women having a low risk pregnancy,
- ensure midwives are competent to deal with the potential emergency situations that may occur in any labour, and
- allow access to best practice diagnostics and technology in order to support proactive identification of problems and appropriate and timely referral or treatment.\footnote{College Proposed Routine and Extended Scope of Practice for Midwives of Ontario - response to July Document provided to roundtable participants. Summary Chart (Introduction) of the Proposed Routine and Extended Scope of Practice for Midwives – August 2008.}

The specific requests HPRAC has grouped under high risk births and emergency situations include the procedures listed below. HPRAC has based its classification of these activities on the review of the literature on normal and high risk pregnancies, on a key informant interview with Dr. André Lalonde, executive vice-president of the Society of Obstetricians and Gynaecologists of Canada and on the written submission received from OCFP. These high risk procedures raise common issues of risk of harm and also issues concerning the appropriate use of sections 28 and 29 of the \textit{RHPA}.

Each of the following requests involves a specific clinical procedure that may or may not be required during the course of labour and delivery and immediately following delivery. Three of the requests seek clarification of authority, while two seek new authority to perform controlled acts.

1. Clarification of authorization to the existing controlled act of putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period to allow:
   i. Manual removal of the placenta,
   ii. Perform vacuum extraction, and
   iii. Foetal scalp PH tests.

2. Clarification of authorization to the existing controlled act of performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area by authorizing performing episiotomies and amniotomies and repairing episiotomies and lacerations, to allow repairs of 3rd degree tears and provide care related to 4th degree tears.

3. Clarification of authorization to the existing controlled act of taking blood samples from newborns by skin pricking or from women from veins or by skin pricking to allow:
Chapter 3 – Review of the Scope of Practice of Midwifery

- Fetal scalp PH tests, and
- Umbilical vein catheterization.

4. Authorization for a controlled act of putting an instrument, hand or finger beyond the larynx for the purpose of resuscitation of the newborn to allow:
   - Intubating of newborns.

5. Authorization for a controlled act of putting an instrument, hand or finger beyond the anal verge for the purpose of routine perineal repair procedures and the administration of suppository medications to allow:
   - Repair of routine perineal procedures.

The CMO advised HPRAC that midwives are already educated and trained to undertake most of these procedures. The CMO is seeking clarification so it can interpret the legislation to include activities such as manual removal of the placenta, vacuum extraction, foetal scalp PH tests, and umbilical vein catheterization.

The CMO said that for both the requests for clarification and for the new authorized acts, midwives are either already sufficiently educated and trained to perform the procedures, or would require minimal additional education and training. The CMO claims that midwives have the training, through the Canadian Pediatrics Society Neonatal resuscitation program, which they are required to take once every two years, to provide some emergency procedures, such as newborn intubation and umbilical catheterization.\(^{119}\)

As a result of information gathered in its review, HPRAC finds that all of the requests put forward concerning high risk births or emergency situations pose extremely high risks of harm to the mother and baby. HPRAC has concluded that the need for each of these procedures is an indication of a high risk, non-normal birth, or an emergency situation.\(^{120}\) According to the SOGC, some of these procedures are only performed in extremely rare circumstances.

The risk of harm of these procedures, and the perception that midwives want to practice beyond normal, low risk births, was a key concern raised during HPRAC’s consultations. HPRAC heard significant opinion, from midwives and others, that extending midwifery services into complex high risk obstetrical care could compromise patient safety and lead to more complicated emergency care requirements. HPRAC was frequently told that the greatest human resource need in maternity care is not in high risk births, but rather in the low risk, normal births where midwives excel.

Several interested parties, including the SOGC, the OCFP, and the OMA, do not agree that these procedures should be performed by midwives as part of an expanded scope of practice. They told HPRAC that they require highly trained professionals who have regular exposure to such demanding situations. Several procedures, such as newborn intubation, 3\(^{rd}\) and 4\(^{th}\) degree tear repairs, and the manual removal of the placenta, are rarely done by family physicians, who automatically refer patients to an obstetrician. Some of these procedures should only be done in a hospital with the appropriate sterile conditions and other essential supports.

\(^{119}\) See above section: Continuing Competence and Quality Assurance.

Both the SOGC and the OCFP say that in the case of an emergency, if a midwife is the only health professional available and transfer is not possible, a midwife must do whatever is necessary to try to save the mother, foetus or baby by using skills learned through emergency training. The authority for emergency actions is provided under sections 28 and 29 of the RHPA. The SOGC underlines that at the first indication of an enhanced risk or complication, the immediate response should be to transfer the patient to a specialist in high risk deliveries rather than to begin any of these procedures, and that in virtually all circumstances there is time to do this transfer. Additionally, beginning complicated procedures can, and often do, lead to increased complications in labour and delivery.

The CMO does not have a standard of practice or guideline that limits certain procedures to a hospital setting. HPRAC concludes that none of these procedures should be attempted in a home birth.

The CMO has a Policy on Continuing Competency in Emergency Skills. Submissions from educators from Ryerson University and Laurentian University provided additional information about the revised curriculum developed by the Midwifery Education Program (MEP), which will be implemented in September 2009 for the third and fourth years of the program. Additional education in high risk procedures will be included in the new curriculum.

However, only one of the five clinical training placements for midwifery students is in a community setting with other health care professionals. As a result, students’ exposure to complex procedures and high risk births is limited. The MEP has identified this gap in midwives’ clinical training. From information it received during the course of this review, HPRAC is persuaded that many of the requests from the CMO concerning high risk and emergency situations require ongoing clinical exposure to maintain competency.

Addressing emergency situations and complications that may arise during labour and birth is inherently complex, especially in the context of remote and underserviced areas. HPRAC appreciates these issues, though it concludes that the RHPA emergency provisions adequately address them.

The CMO referred to midwives’ annual certification in the Canadian Pediatric Society’s Neonatal Resuscitation Program (NRP) as sufficient to maintain competency and to authorize midwives to perform newborn intubation in an emergency situation. HPRAC has been advised by both the SOGC and the OCFP that this procedure is an extremely high risk and complicated one, and should be performed only by a highly specialized health professional. A two day NRP refresher course once every two years is insufficient to maintain clinical capacity in the absence of continuing clinical exposure. This is true for any health care provider involved in primary maternity care, and not just for midwives. Since family physicians are not able to maintain their competency through their day-to-day practice, they refer these procedures to obstetricians or other specialists.

The CMO’s survey indicates moderate support among members for midwives performing certain extended skills such as Scalp PH (69.9 percent) and perineal repairs (61.4 percent), and lower support for performing 3rd and 4th degree tear repairs (47.1 percent).

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122 Vicki Van Wagner, Associate Professor, Ryerson University. Submission Respecting the Scope of Practice of Midwives. April 2008; Susan James, Program Director, Laurentian University. Submission Respecting the Scope of Practice of Midwives. August 2008.
http://www.midwifery.laurentian.ca/Laurentian/Home/Departments/Midwifery/current_students/community_placements.htm
Chapter 3 – Review of the Scope of Practice of Midwifery

The jurisdictional review indicates that some jurisdictions in Canada authorize some of these activities. However, they are either specifically limited to emergency situations or to midwives who have satisfied advanced practice requirements and include an automatic referral to a physician. These activities are not generally authorized to midwives across Canada.

Recommendation:

6. That the *Midwifery Act, 1991* and regulations made under it should not be amended to clarify existing authorized acts.

7. That the *Midwifery Act, 1991* should not be amended to authorize repair of routine perineal procedures and 3rd degree tears, to provide care related to 4th degree tears and intubation of newborns.

8. That the CMO should develop comprehensive standards of practice (limitations and conditions) for emergencies, that these standards should be incorporated into the CMO's *Indications* document, and indicate the education and clinical training required to maintain competency for emergency procedures.

Requests for Amendments to Other Legislation

Laboratory and Diagnostic Tests for the Purpose of Screening and Testing

The CMO has requested amendments to regulations under several statutes to allow midwives to order additional laboratory and diagnostics tests, including ultrasounds on a newborn. The CMO submission highlighted examples of the tests being requested, and a list of more than 20 additional laboratory and diagnostic tests was included as an appendix to the submission.

The CMO said these tests are necessary to ensure that midwives can provide care using best practices, and that midwives would consult and refer appropriately based on the test results.

HPRAC did not conduct a technical and clinical review of the purpose of each of the laboratory and diagnostic tests. Midwives are currently authorized under the *Laboratory and Specimen Collection Centre Licensing Act* to order some laboratory tests within their scope of practice, but the CMO has indicated that the current list of tests does not include many that are required for care throughout a normal, healthy pregnancy. The OMA and the OCFP have said that some of the tests listed, including pregnancy induced hypertension (PIH) and cord blood gases, may indicate a higher risk, non-normal pregnancy that should be referred to a specialist.

Authorizing midwives to order the additional laboratory tests and diagnostics may result in better patient care by enabling a midwife to identify potential risk factors earlier. In its analysis, HPRAC agreed with the CMO’s position that midwives should be able to order and consider the results of diagnostic tests that might indicate a complication in the pregnancy, so they can determine whether a referral to a specialist is required, or if they should continue with the course of care. Patients would consider this responsible care,

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125 For example, Alberta, the North West Territories and Quebec have mandatory consultation requirements. See Midwifery Jurisdictional Review. August 2008.
and an expected professional duty. HPRAC sees a comprehensive CMO referral protocol as a necessary adjunct to the authority to order additional tests.

The authority to order laboratory tests for screening and testing varies across Canadian provinces and territories. Some jurisdictions authorize or exclude particular tests while others give midwives broad authority to order tests. In some jurisdictions, evidence of advanced competency is required.126

The College of Physicians and Surgeons of Ontario supports the CMO’s request for authorization to order additional laboratory tests, including cord blood, blood screen, PIH and vaccines.

Recommendation:

9. That midwives be granted access to order additional laboratory tests and diagnostics, consistent with their scope of practice.

10. That the regulations made under the Midwifery Act, 1991 should require the College to develop standards of practice for the ordering of diagnostic tests through a process of interprofessional collaboration with other regulated health professions, individuals and entities.

11. That the standards of practice should indicate the diagnostic tests that midwives should be authorized to order, the clinical purpose for the tests, the competencies required for the interpretation of the tests, and the protocols for referral to a specialist.

Postpartum Ultrasounds

The CMO has also requested amendments to the RHPA Regulation 107/96 to authorize the ordering of maternal postpartum ultrasounds and newborn follow-up ultrasounds. This is in addition to their current authorization to order the application of sound waves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound. The CMO has proposed the following amendment:

A member of the CMO is exempt from subsection 27(1) of the Act for the purpose of ordering the application of sound waves for pregnancy diagnostic ultrasound, pelvic diagnostic ultrasound, maternal postpartum diagnostic ultrasound or newborn follow-up diagnostic ultrasound.

The OCFP and the OMA said that in almost all circumstances, the need to order a newborn ultrasound suggests an abnormality and requires that the newborn be immediately referred to a paediatrician. The CMO’s detailed Indications document already guides midwives on the necessary protocol to consult and refer a patient to a physician.

A follow-up neonatal ultrasound is not specifically authorized in other jurisdictions in Canada. In the Northwest Territories and Saskatchewan, the authority is inferred under a broad authorization for ultrasounds. In the Northwest Territories, midwives who can demonstrate additional education and training are authorized to perform the ultrasound.127

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In other jurisdictions, any authority for postpartum ultrasounds are limited to pelvic and obstetrics ultrasounds on the mother.\textsuperscript{128}

**Recommendation:**

12. That midwives not be authorized to order maternal postpartum ultrasounds and newborn follow-up ultrasounds.

**Amendments to Prescribe and Administer Additional Drugs**

The CMO has requested amendments to the Designated Drugs Regulation O. Reg. 884/93. Currently, the CMO has an amendment request before the Ontario Ministry of Health and Long-Term Care that includes the drugs detailed in its submission.

**Antibiotics**

The CMO lists over 20 drugs, including several antibiotics.\textsuperscript{129} HPRAC heard that, within its current scope of practice, Ontario midwives do not have the authority to order antibiotics, unlike other Canadian jurisdictions, where there is broad authority to prescribe antibiotics. HPRAC is particularly concerned that midwives are not authorized to prescribe antibiotics for Group B Streptococcus. During the consultations HPRAC heard numerous examples of the need to prescribe antibiotics to provide appropriate and safe patient care.

**Oxytocin**

The CMO has requested authority to prescribe and administer oxytocin, a drug that is used for two purposes in labour and delivery: postpartum, to contract the uterus to decrease bleeding, or intrapartum, to contract the uterus to augment labour. Oxytocin has known complications, and it is classified as a high alert medication by the Institute of Safe Medication Practices. Such a classification implies that these substances “bear a heightened risk of causing significant patient harm when they are used in error.”\textsuperscript{130}

The authority to prescribe oxytocin varies across jurisdictions. In British Columbia, it must be ordered and administered by a physician, and its use is restricted to a hospital setting for the purposes of augmentation and induction of labour.\textsuperscript{131} British Columbia is currently considering the use of oxytocin in specialized midwifery practice. In Manitoba, administering oxytocin is limited to postpartum use and Saskatchewan requires advanced competency for its administration. In Alberta, midwives are authorized to administer oxytocin intravenously or in muscles and the dosage is controlled by guidelines.\textsuperscript{132}

\textsuperscript{128} Ibid.
\textsuperscript{129} The College of Midwives of Ontario Submission to HPRAC. Appendix F. May 30, 2008.
\textsuperscript{130} Institute for Safe Medication Practices. ISMP’s List of High Alert Medications.
Next Steps

The Minister of Health and Long-Term Care has requested HPRAC to provide advice concerning those non-physician professionals who prescribe and use drugs in the course of their practice. While HPRAC does not want to prejudge the work or conclusions of that review, HPRAC has heard broad justification for midwives to prescribe certain antibiotics for certain conditions. There are risk of harm issues concerning the misuse of antibiotics, such as the development of antibiotic drug resistance and opportunistic infections. The risks and benefits of midwife antibiotic prescribing will be considered in HPRAC’s parallel work, along with the CMO requests for authority to order other prescription drugs, such as oxytocin, and to order and administer vaccines.

To amend the Ambulance Act to authorize midwives to direct an ambulance to the most appropriate care facility

The CMO has requested that the Ambulance Act be amended to authorize midwives to direct an ambulance to what the midwife judges to be the most appropriate care facility. The CMO claims that the Ambulance Act was amended without proper consultation with the midwifery profession and does not reflect the integration of midwifery into the health care system. The CMO claims that the principles of patient safety, continuity of care, and clinical experience support midwives having authority during an ambulance transport.

Notwithstanding the CMO’s position, HPRAC finds that changing the regulations to support this request would pose a serious risk to patients. The SOGC, the OFCP and the OMA objected to this request. The OCFP emphasized that an ambulance must always go to the nearest hospital with capabilities to meet the patient’s needs.133

HPRAC is not persuaded that amending the Ambulance Act to expand midwives’ authority to direct an ambulance is in the public interest. The amendments to the Ambulance Act were made following a lengthy consultative process and HPRAC has serious concerns about the risk of harm to patients if midwives could direct the ambulance independent of the emergency protocols in place under that Act.

Resolving the problem of an attending midwife who does not have credentials at the hospital to which the ambulance is directed, can better be addressed through the CMO’s discussions with the OHA.

HPRAC sees the CMO’s request as an example of an attempt to remove a perceived structural barrier that could seriously impact patient safety if granted.

Recommendation:

13. That no change to the Ambulance Act be made.

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133 Submission from the OCFP to HPRAC in Respect to the College of Midwives of Ontario Scope of Practice Review. August 15, 2008. p. 11.
Communicating a Diagnosis within the Scope of Midwifery Practice

The CMO has requested the authority to communicate a diagnosis as follows:

Communicating to a client or to his/her representative a diagnosis made by the member identifying, as the cause of the patient’s symptoms, a disease or disorder that can be identified from the results of any tests or assessments that the member is authorized to order or perform within the scope of midwifery practice.

In support of its request, the CMO claims that midwives are already authorized to screen and order tests for a wide range of conditions. They claim that the goal of the request is the timely detection of potential abnormalities at the point of care, and state that midwives would continue to refer appropriately.

Midwives currently have the authority to assess their patients and order tests. The CMO has said that if midwives were granted the authority to communicate a diagnosis, the Midwifery Education Program would need to ensure that midwives are educated, trained and competent to do so.

Currently, no Canadian jurisdictions allow specific authority to midwives to communicate a diagnosis. However, communicating a diagnosis is not a restricted activity in any of the other Canadian jurisdictions. The College of Midwives of British Columbia has a number of proposals before the Ministry of Health, including a request for the authorization to communicate a diagnosis, as follows:

“midwifery diagnosis” means a clinical judgment of a woman’s physical or mental condition, or that of her newborn, to determine whether the condition can be addressed by interventions within the registrant’s scope of practice to achieve outcomes for which the registrant is accountable or whether consultation with or transfer of care to another health professional is required.

Other Canadian jurisdictions infer the authority based on a combination of statute, regulations and standards of practice, but all use the word assessment rather than diagnosis.

The College of Physicians and Surgeons of Ontario supports the midwifery request for the authorized act of communicating a diagnosis.

Building on HPRAC’s recommendations relating to additional laboratory tests and diagnostics, HPRAC recommends that midwives be granted the controlled act of communicating a diagnosis based on a midwifery assessment. HPRAC observes that care can be improved if midwives can clearly communicate a diagnosis to a patient, and the patient can make decisions as a result, including decisions on transfer of care. It is also critical that a midwife be able to communicate diagnostic findings to other members of the maternity care team so appropriate care steps can follow.

Recommendation:

14. That midwives be authorized to communicate a diagnosis of a disease, disorder or dysfunction that may be identified through a midwifery assessment.

135 College of Physicians and Surgeons of Ontario (CPSO). Letter to Barbara Sullivan, Chair of HPRAC, from Rocco Gerace, Registrar of the CPSO. August 21, 2008.
Chapter 3 – Review of the Scope of Practice of Midwifery

Amendments to the Scope of Practice Statement

The CMO has requested a change to the scope of practice statement in the Midwifery Act, 1991 to reflect the additional activities being requested, including access to new authorized acts. The scope of practice statement found in each health profession-specific Act under the RHPA provides a frame of reference for the performance by regulated health professionals of their authorized acts. Regulated health professionals may perform their profession’s authorized acts only in the course of practising within the profession’s scope of practice.

A scope of practice statement should be amended only in the following situations:

- When an act is added to the list of authorized acts conferred upon a health profession, and
- When HPRAC is satisfied that its criteria for a change in a scope of practice have been met.

This analysis takes place when HPRAC considers the expansion of a health profession’s authorized acts. That is, HPRAC asks: will an expanded scope of practice statement encompass a new assessment, diagnostic, treatment or prevention opportunity for the profession that was previously prohibited? And: is this expansion necessary or desirable?

HPRAC’s Review of a Professional Scope of Practice under the RHPA concluded that a scope of practice includes many elements, one of which is the scope of practice statement. To determine whether the scope of practice statement for midwives should be amended, HPRAC considered whether midwives should be granted additional controlled acts and for what purposes.

The CMO has requested changes to its scope of practice statement that incorporate its requests for changes relating to routine practice and extended practice. It proposes that the scope of practice statement in the Midwifery Act, 1991 should read:

The practice of midwifery is:

i. The assessment and monitoring of the health of a woman and her baby during the normal course of pregnancy, labour and the postpartum period,

ii. The provision of care related to the normal course of pregnancy, labour, and the postpartum period, including counselling, support and advice, and

iii. The management of vaginal deliveries.

Normal Birth

A major request involving the routine scope of practice of midwives is to remove the qualifying terms “normal” and “spontaneous” from the description of the deliveries midwives manage that is contained in the current scope of practice statement. The CMO said this step was needed for midwives to provide pre-conception counselling, to create more flexibility in scope of practice, and to reflect the acts that are currently within a midwife’s scope of practice, such as conducting artificial rupture of the membranes for induction of labour. The CMO told HPRAC that what constitutes a “normal” birth is contested and, since it has been interpreted in many different ways, is not appropriately included in the statute.

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HPRAC carefully reviewed this claim. All Canadian jurisdictions that regulate midwifery include the terms “normal” and “spontaneous” to describe the midwifery scope of practice.\textsuperscript{137} Normal and spontaneous births form the core of midwifery philosophy of care, and the CMO has also said that it is not looking to change this fundamental position.

Several countries, including Canada, have made attempts to establish guidelines for normal pregnancy and birth. The Society of Obstetricians and Gynaecologists of Canada has developed a draft policy statement on normal childbirth. Currently unpublished, the draft statement has been endorsed by the Canadian Association of Midwives (CAM), the Association of Women’s Health, Obstetric and Neonatal Nurses of Canada (AWHONN), the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC).\textsuperscript{138} This draft statement defines normal birth as:

A normal birth is spontaneous in onset, is low risk at the start of labour and remains so throughout labour and birth. The infant is born spontaneously in vertex position between 37 and 41+7 [days] completed weeks of pregnancy and has the opportunity for skin-skin holding and breastfeeding in the first hour after the birth. A normal birth may include:

- Augmentation of labour,
- Artificial rupture of the membranes if it is not part of medical induction of labour,
- Nitrous oxide and opioids (non pharmacologic and pharmacologic pain relief), epidural,
- Intermittent fetal auscultation,
- Managed third stage of labour, and
- Antenatal, birth, or postnatal complications (this may include postpartum hemorrhage, perineal tear and repair of perineal trauma, admission to the neonatal intensive care unit).

A normal birth does not include: elective induction of labour prior to 41+0 [days] weeks, spinal analgesia, general anaesthetic, forceps or vacuum assistance, Caesarean section, routine episiotomy, continuous electronic fetal monitoring for low risk birth and fetal malpresentation.\textsuperscript{139}

In Britain, the Maternity Care Working Party, which includes the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, defines normal labour and birth as:

Without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery.\textsuperscript{140}

This normal delivery group includes:

1. Women whose labour starts spontaneously, progresses spontaneously without drugs, and who give birth spontaneously,
2. Women who experience any of the following provided they do not meet the exclusion criteria (see below):
   a. Augmentation of labour,
   b. Artificial rupture of membranes (ARM) if not part of medical induction of labour,
   c. Entonox,
   d. Opioids,
   e. Electronic foetal monitoring;
   f. Managed third stage of labour,
   g. Antenatal, delivery or postnatal complications, including for example, postpartum haemorrhage, perineal tear, repair of perineal trauma, admission to neo-natal intensive care unit.

The normal delivery group excludes women who experience induction of labour (with prostaglandins, oxytocics or ARM); epidural or spinal general anaesthetic; forceps, ventouse (also called vacuum-assisted vaginal delivery or vacuum extraction) or caesarean section delivery or an episiotomy.\[141\]

The OCFP said that removing the words "normal" and "spontaneous" from the midwifery scope of practice statement implies that midwifery practice routinely encompasses the management of complicated and high risk births.\[142\]

As a result of its conclusions concerning requests to perform additional activities including new authorized acts, and its view that midwives are competent to provide high quality primary maternity care for normal and low risk births, HPRAC does not find that a change to the scope of practice statement is warranted or necessary. HPRAC does not see changing midwifery’s scope of practice statement as the appropriate solution to address structural barriers facing the profession.

**Extended Practice**

The CMO requested the creation of an extended practice for midwifery, and reflected the broader activities contemplated for this class in its proposal for the revision of the scope of practice statement for the profession.

The CMO requested a change to extend the practice of midwifery to several months beyond the current six weeks post partum to include well baby and well woman care, and to include pre-conception counselling for women. The rationale for this request was to increase access to care at the point of care, and particularly to benefit women in underserviced areas of the province facing health human resources shortages. It was suggested in HPRAC’s consultations that this extension would provide midwives with an opportunity for increased full-time work in geographical areas where the birth rate is low and midwives are not occupied on a full-time basis, and where physician supply is low.

HPRAC was advised that the CMO had just begun its work on a possible extended practice class of registrant, including engaging in dialogue and consultation with the profession, educators and relevant stakeholders. The CMO referred to a working group that will address the competencies of midwives in an extended class and the capacity of educators, the profession and the health care system.

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\[141\] Making Normal Birth a Reality. p. 3.
\[142\] Submission from the OCFP to HPRAC in Respect to the College of Midwives of Ontario Scope of Practice Review. August 15, 2008. p. 6.
HPRAC considered the CMO’s request for proposed routine and extended practice categories of registration under the *Midwifery Act, 1991*. HPRAC notes that while nurse practitioners are registered as an extended class by the College of Nurses of Ontario, no other professions in Ontario regulate a separate class for what is more commonly described as advanced practice. HPRAC supports the concept of an individual scope of practice, where a professional must practice only within individual competencies that are established with the regulatory college. In general, HPRAC does not think it is necessary for health regulatory bodies to establish separate registration practice classes, and notes that doing so adds significantly to the complexity of the regulatory process.

There was minimal support for this request, other than among some midwives. The OCFP viewed this request as one that potentially encompasses the expertise of nurses, family physicians and pediatricians in midwifery practice. HPRAC sees many of the procedures contemplated under an extended practice category as fundamentally changing the role of midwives in primary maternity care.

In HPRAC’s view, many of the CMO’s requested changes to the scope of practice of midwifery in Ontario would significantly change the nature of the profession.

HPRAC has concluded that the requested activities relating to the extended scope of practice and associated changes to the scope of practice statement for midwifery should not be adopted at this time. HPRAC does not recommend an extended practice registration category for midwifery.

**Recommendations:**

15. That no changes be made to the scope of practice statement in the *Midwifery Act, 1991*.

16. That an extended class registration category for members of the College of Midwifery not proceed.

**Breaking Down the Barriers**

As a result of its research and consultations, HPRAC has concluded that the midwifery scope of practice is not at the core of the challenges facing maternity care in Ontario. A significant expansion of midwifery’s scope of practice is not the solution. In its assessment of each request for an expansion of midwifery practice, HPRAC has examined other opportunities to increase access to primary maternity care through interprofessional collaboration that will manage the risk of harm to patients and ensure individual midwives can practice to their maximum competence.

In its review, HPRAC heard of a number of structural barriers facing the practice of midwifery in Ontario today. These barriers reflect challenges facing midwives in their day-to-day practice, as well as challenges to the development of effective interprofessional maternity care. Addressing these barriers will enable midwives to work to their full scope of practice. Some of the key issues that have been identified include:

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143 The College of Midwives of Ontario Submission to HPRAC. p. 23-24.
Chapter 3 – Review of the Scope of Practice of Midwifery

- Regulatory requirements,
- Hospital credentialing process,
- Inconsistent hospital midwifery policies across Ontario,
- Funding (formula, number of births per midwife, regional model, independent birthing centres),
- Compensation models (interprofessional teams, fee-for-service, course of care, family health teams), and
- Cultural issues.

Initiatives are underway to address some of the constricting regulatory requirements. As noted, the CMO is reconsidering some of its policies and guidelines, including:

- the requirement that there be two midwives at every birth,
- the current active practice requirements, including rules relating to association with other health professionals,
- the continuity of care requirements,
- the guidelines for certification to work outside the primary scope of practice, and
- the CMO standard Indications for Mandatory Discussion, Consultation, and Transfer of Care.¹⁴⁵

To address some of the limitations in the profession’s active practice requirements, which are contained in a regulation made under the Midwifery Act, 1991¹⁴⁶, HPRAC is recommending that the requirements be revoked and that the proposed Midwifery Standards Committee address the active practice requirements. This approach will provide flexibility for the CMO and ensure the involvement of other maternity care professions in developing joint standards for maternity care. It will also provide assurance to patients that they will receive the highest standards of care.

The OMCEP Report, Emerging Crisis, Emerging Solutions, made a number of recommendations for a comprehensive provincial approach to providing maternity care in Ontario.¹⁴⁷ In addition to their key recommendation to establish an Office of Maternal Newborn Health, some of their recommendations addressed systemic issues mentioned above, as well as some specific issues regarding midwives and their relationship – regulatory, structural, economic or otherwise – to the maternity care system.

It was clear throughout HPRAC’s consultations that midwives and other maternity and obstetrical professionals are convinced of the need to develop a variety of means to deliver more effective interprofessional primary maternity care.

In June 2008, the AOM developed a detailed paper, Midwives and Interprofessional Care, outlining a number of recommendations to enhance collaborative maternity care. The SOGC, through its work in the MCP² and its follow-up document, A National Birthing Initiative for Canada, and the OMCEP, in Emerging Crisis, Emerging Solutions, strongly support the development and implementation of interprofessional maternity care models. The AOM has recommended that Ontario:

- earmark specific funds to support collaborative maternity care pilot projects in communities that possess both the need and the providers willing to participate. Pilot projects will enable thorough evaluation and relevant “lessons learned” for subsequent initiatives.

¹⁴⁵ The College of Midwives of Ontario Submission to HPRAC. p. 24.
¹⁴⁷ OMCEP. Emerging Crisis, Emerging Solutions. Appendix A.
Chapter 3 – Review of the Scope of Practice of Midwifery

- Update the *Public Hospitals Act* to ensure midwives are guaranteed due process and right of appeal concerning hospital credentialing and representation on committees that determine credentialing.

- Direct LHINs [Local Health Integration Networks] to establish consistent guidelines for the integration of midwives into all hospitals that offer maternity care, including guidelines for credentialing and guidelines that ensure midwives are able to work to their fullest scope possible. Midwives must be able to work to their full scope in order to be fully integrated into hospitals and to fully participate in IPC models. Direct LHINs to offer incentives to hospitals that fully integrate midwives.

- Create funding mechanisms for compensating midwives involved in interprofessional maternity care models that are equitable both within new interprofessional models and also with midwives working in the current Ontario model. Adequately compensate obstetricians to provide on-call back up for consultations and referrals from midwives. Physicians must be compensated to be available for high risk transfers of care. Likewise, other specialists such as pediatricians or anaesthetists need to be compensated for direct referrals from midwives.

- In conjunction with the Ministry of Training, Colleges and Universities, earmark funds to enhance interprofessional education within the Midwifery Education Program for midwifery students, medical students, residents, nursing students and other health care providers. The MEP, at each of its three sites at Ryerson, McMaster and Laurentian, is an ideal group to provide interprofessional education with a specific focus on maternity care.

- Fund birth centres for low risk normal births and as model sites of interprofessional education and practice. Interprofessional education is essential to the success of interprofessional maternity care and birth centres offer an ideal environment for providers to learn from, with, and about each other.

HPRAC recommends that the government consider exploring a variety of primary maternity care models for the delivery of low risk, normal births. This is consistent with the OMCEP and MCP² reports that emphasize structural barriers facing the delivery of primary maternity care and the implementation of interprofessional models as a key solution.

The government, through the establishment and expansion of nurse practitioner-led clinics, family health teams and other alternative primary care models, has demonstrated a willingness to explore a variety of options to enhance interprofessional primary care.

Throughout the consultations, HPRAC heard enthusiastic support for free standing birth centres, which are meant to be an option between the home and hospital settings for low risk, normal births. This viewpoint is consistent with the OMCEP’s recommendation for the Ministry of Health and Long-Term Care to establish and evaluate Centres of Excellence for Normal Birth to facilitate interdisciplinary education and research to support low intervention models of care.

As an appendix to its submission to HPRAC, the CMO provided detailed Facility Standards and Clinical Practice Parameters for Free Standing Birth Centres under the *Independent Health Facilities Act*. This document was developed by the CMO in 1995 and, since that time, there have been no birth centres established under this legislation. It is time to consider this option. It is also essential for birth centres or clinics to be closely linked to local hospitals, and have shared protocols for high risk and emergency situations. Such models would effectively integrate all of the key players in primary maternity care.

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149 OMCEP. *Emerging Crisis, Emerging Solutions*, p. 159.
enabling them to work to the full extent of their scopes of practice and maximize the use of scarce specialized health human resources.

HPRAC is persuaded that such interprofessional primary maternity care models ought to be considered by the government as one element of a strategy to address the crisis in primary maternity care in Ontario. Proven models exist that could be adopted as pilot or demonstration projects that, similar to family health teams, would require alternative payment methods for the health professionals involved. In addition to midwives, a number of maternity care professionals including obstetricians, gynecologists, family physicians, nurses, nurse practitioners and lactation consultants, among others, should be involved in the strategic development and implementation of new models.

HPRAC views the need for joint education and training, and the development of common clinical standards as recommended by *A National Birthing Initiative for Canada*, as one of the key components of interprofessional primary maternity care.

**Conclusions**

HPRAC sees midwives as providing high quality primary care maternity services for low risk, normal births in Ontario, with a significant role in addressing challenges in maternity care both now and in the future. The profession should be granted added tools to provide its expertise, such as the authority to communicate a diagnosis and to order additional diagnostic tests, according to best maternity care practices. The urgency in maternity care is not in the high risk sector, but rather in caring for the majority of women who experience normal births. This is where midwives excel and, for these reasons, HPRAC believes that this is where their competencies should be emphasized, and where barriers to their performance should decrease.

**Implementation Proposals**

To implement HPRAC’s recommendations, the following changes to statutes and regulations are proposed:

1. That section 4 of the *Midwifery Act, 1991* be repealed and the following substituted:

   **Authorized acts**

   4. In the course of engaging in the practice of midwifery, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:
      1. Communicating a diagnosis of a disease, disorder or dysfunction that may be identified through a midwifery assessment.
      2. Managing labour and conducting spontaneous normal vaginal deliveries.
      3. Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area.
      4. Administering, by injection or inhalation, a substance designated in the regulations.
      5. Putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period.

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Chapter 3 – Review of the Scope of Practice of Midwifery

6. Putting an instrument, hand or finger beyond the anal verge for the purpose of administering suppository drugs designated in the regulations.

7. Taking blood samples from newborns by skin pricking or from women, fathers or sperm donors from veins or by skin pricking.

8. Inserting urinary catheters into women.

9. Prescribing drugs designated in the regulations.

2. That the Midwifery Act, 1991 be amended by adding the following sections:

   **Additional requirements for authorized acts**
   
   4.1 A member shall perform a procedure under the authority of section 4 in accordance with any requirements prescribed in the regulations.

   **Individual scope of practice for midwives**
   
   4.2 A member is responsible for identifying the limits of his or her educational preparation and competencies, and for resolving situations beyond his or her expertise by consulting with or referring patients to other health care professionals.

3. That section 11 of the Midwifery Act, 1991 be repealed and the following substituted:

   Regulations

   11. **(1)** Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council may make regulations,

   (a) designating the substances that may be administered by injection or inhalation by members in the course of engaging in the practice of midwifery;

   (b) designating the drugs that may be prescribed by members in the course of engaging in the practice of midwifery;

   (c) specifying the drugs that a member may use in the course of engaging in the practice of midwifery;

   (d) specifying requirements for the performance of procedures under the authority of section 4.

4. That Ontario Regulation 867/93 under the Midwifery Act, 1991 be amended by adding the following:

   3.1 It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of section 4 of the Act must ensure the procedure is performed in accordance with any standards of practice established by the College from time to time.

   3.2 It is a term, condition and limitation of a certificate of registration of any class that the holder must comply with the standards, limitations and conditions set out in the publication of the College entitled “Indications for Mandatory Discussion, Consultation and Transfer of Care Guideline”, as that publication is amended by the College from time to time.

5. That section 5 of Ontario Regulation 867/93 under the Midwifery Act, 1991 be deleted.
6. That Ontario Regulation 867/93 under the *Midwifery Act, 1991* be amended by adding the following:

**STANDARDS OF PRACTICE**

10.1 The College shall develop, establish and maintain standards of practice for those procedures performed under the authority of section 4 of the Act that are referred to in section 3.1.

10.2 The College shall develop, and if required amend from time to time, the publication entitled “Indications for Mandatory Discussion, Consultation and Transfer of Care Guideline” referred to in section 3.2.

10.3 The standards of practice referred to in section 3.1 and the publication referred to in section 3.2 shall be developed on the recommendation of the Midwifery Standards Committee.

10.4 For the purposes of section 10.3, the College shall establish the Midwifery Standards Committee referred to in section 10.3 and shall appoint the membership of the Midwifery Standards Committee, which shall include, at a minimum, one or more:

a) members of the Council;
b) members of the College (including practitioners and educators);
c) persons who are not and have not been members of the College or of the Council;
d) members of the College of Physicians and Surgeons of Ontario, approved by the College of Physicians and Surgeons of Ontario, who practice obstetrics, gynecology or family medicine;
e) members of the College of Nurses of Ontario, approved by the College of Nurses of Ontario; and
f) members of the College of Medical Laboratory Technologists of Ontario, approved by the College of Medical Laboratory Technologists of Ontario.

10.5 The College shall post the standards of practice referred to in section 3.1 and the publication referred to in section 3.2 on its website.

7. That Appendix B of Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding the tests determined by the College on the recommendation of the Midwifery Standards Committee.
Review of the Scope of Practice of Dietetics

Index

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPRAC’s Central Response</td>
<td>132</td>
</tr>
<tr>
<td>Background on Dietetics in Ontario</td>
<td>132</td>
</tr>
<tr>
<td>Dietetics’ Scope of Practice</td>
<td>133</td>
</tr>
<tr>
<td>What the Profession has Proposed</td>
<td>133</td>
</tr>
<tr>
<td>Current Competency Requirements</td>
<td>135</td>
</tr>
<tr>
<td>What HPRAC Learned from Research</td>
<td>136</td>
</tr>
<tr>
<td>Perspectives from the Consultations</td>
<td>137</td>
</tr>
<tr>
<td>HPRAC’s Observations</td>
<td>141</td>
</tr>
<tr>
<td>Access to Existing Controlled Acts</td>
<td>142</td>
</tr>
<tr>
<td>New Controlled Acts</td>
<td>147</td>
</tr>
<tr>
<td>Scope of Practice Statement</td>
<td>149</td>
</tr>
<tr>
<td>Amendments to Related Legislation</td>
<td>150</td>
</tr>
<tr>
<td>Conclusion</td>
<td>153</td>
</tr>
<tr>
<td>Implementation Proposals</td>
<td>153</td>
</tr>
</tbody>
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Review of the Scope of Practice of Dietetics

The College of Dietitians of Ontario (the College) and Dietitians of Canada (the Association) submitted a joint response to HPRAC’s scope of practice questionnaire. HPRAC carefully considered this submission, the results of its literature and jurisdictional reviews, and information obtained through its extensive consultation program, in developing its recommendations.

HPRAC’s Central Response

HPRAC sees clinical dietitians as important members of interprofessional teams in primary, secondary and tertiary care, providing specialized technical expertise to assist people of all ages, whether that care is delivered in hospitals, long-term care, the community or the home. The strength of this profession is its unique place in multi-disciplinary patient care, bringing its knowledge and skills to a team whose members together make decisions and deliver care to patients. HPRAC recommends that dietitians receive additional tools so they can better contribute to team-based care, and to the education and monitoring of patients who rely on their skills.

Background on Dietetics in Ontario

Dietitians are essential members of the health care team. They are highly educated in the sciences relating to food and human nutrition and occupy a number of roles in various areas – hospitals, primary health care practices, community health, schools, long-term care, patient homes, government, food industry and private practice. Clinical dietitians identify nutritional problems, assess the nutrition status of patients, develop care plans and monitor the effectiveness of dietary changes. Their patients range from infants through to seniors and present a wide range of medical needs.

The College regulates the practice of dietetics in the public interest. In order to practice as a dietitian in Ontario, one must meet the minimum entry to practice requirements of the College, adhere to the Code of Ethics for the Dietetic Profession in Canada, and practice according to the Professional Standards for Dietitians in Canada as well as the policies and guidelines as set by the College. In addition, all dietitians must participate in the College’s Quality Assurance Program.

In 2006/2007, there were 2,821 registered dietitians in Ontario, 42 percent of whom were in clinical practice. The remainder worked in non-clinical areas such as food and nutrition management, clinical nutrition management, and public health. In 2007/2008, the largest number of dietitians (31 percent), worked in hospitals, 13 percent worked in chronic care or long-term care homes or homes for the aged, and 8 percent in private practice and counselling.

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2 Dietitians of Canada. What Does a Dietitian Do? Available online at http://www.dietitians.ca/public/conent/find_a_nutrition_professional/role.asp
Dietetics’ Scope of Practice

In Ontario, the legislative framework for the health professions includes an umbrella statute, the Regulated Health Professions Act, 1991 (RHPA) and a series of profession-specific Acts that includes the Dietetics Act, 1991. Among other provisions in the RHPA is a list of controlled acts, which are health care activities that carry a substantial risk of harm if performed by unqualified people.

Each profession-specific Act includes a scope of practice statement. The scope of practice statement in the Dietetics Act, 1991 is:

The practice of dietetics is the assessment of nutrition and nutritional conditions and the treatment and prevention of nutrition related disorders by nutritional means.

The profession-specific Acts also set out the controlled acts authorized to the profession. Currently, dietitians are not authorized to perform any of the controlled acts. However, many dietitians perform controlled acts under medical directives or delegation. According to the College and the Association, the competence of dietitians to perform certain controlled acts is shown by the delegation of those acts by other health professionals, and their reliance on the skills and judgment of dietitians to perform them competently.

What the Profession has Proposed

The College and the Association have proposed changes to the scope of practice of dietetics to enable dietitians to practice to their fullest competence. They say that “[dietitians’] expertise in managing nutrition for health promotion, disease prevention, and treatment of acute and chronic diseases is not fully recognized or utilized under the current scope of practice.” Therefore, they have proposed a number of changes, including amendments to the scope of practice statement for the profession.

Scope of Practice Statement

The proposed scope of practice statement is:

Dietetics is the assessment of nutrition related to health status and conditions for individuals and populations, the management and delivery of nutrition therapy to treat disease, the management of food systems, and building the capacity of individuals and populations to promote or restore health and prevent disease through nutrition and related means.

In particular, the proposed changes seek to recognize the significance of nutrition on health status and its impact on patients, as well as describing the diverse roles dietitians assume in various settings.

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6 Dietetics Act, 1991, s. 3
7 College of Dietitians of Ontario and Dietitians of Canada submission, p.10.
8 Ibid, p.16.
Chapter 4 – Review of the Scope of Practice of Dietetics

**Authority to Perform Existing Controlled Acts**

The proposal seeks access to controlled acts, consistent with dietitians’ existing dietetic knowledge, competencies and standards. It says that medical directives and delegation are a barrier to dietitians practising to their maximum potential, as well as a barrier to timely and effective patient care. The controlled acts proposed are:

- Communicating a diagnosis that relates to nutrition therapy when that diagnosis has been confirmed by an authorized professional,
- Performing a procedure below the dermis for the purpose of monitoring capillary blood levels,
- Adjusting insulin or oral hypoglycemic medications as prescribed by an authorized provider, and
- The controlled act of psychotherapy.

**New Controlled Acts**

The College and the Association also propose that two new controlled acts be added to the RHPA, and that dietitians be authorized to perform them autonomously:

- Prescription and management of enteral and parenteral nutrition, and
- Prescription and management of therapeutic diets.

**Changes to Related Legislation**

Amendments are proposed to other legislation:

- Changes to the Public Hospitals Act to add dietitians to the list of professionals authorized to order specified treatment and diagnostic procedures,
- Changes to the Laboratory and Specimen Collection Centre Licensing Act to add dietitians to the list of professionals authorized to order specified tests as prescribed in the legislation,
- Changes to the Health Care Consent Act to enable dietitians to act as evaluators, and
- Changes to the Long-Term Care Homes Act to specify that the dietitian orders and manages nutritional care, including enteral and parenteral nutrition and therapeutic diet orders.

**Rationale for the Proposals**

The College and the Association highlight several barriers to the practice of dietetics in Ontario. Generally, they argue that the importance of nutrition on health status and patient outcomes is not fully recognized, and the expertise of dietitians in the area of nutrition is not fully utilized. The proposed changes seek to raise the profile of dietitians as key members of interprofessional care teams, and to recognize those areas where dietitians are qualified to take lead roles, such as in the management of diabetes and the prescription and management of nutrition therapy.
Chapter 4 – Review of the Scope of Practice of Dietetics

Current Competency Requirements

The College sets the education, registration, quality assurance and continuing competence requirements for the practice of the profession.

Educational Preparation

All dietitians must complete a four-year undergraduate university program in food and nutrition as well as an accredited internship. Dietitians of Canada is the accrediting body for both undergraduate and internship programs. In order to be accredited, programs must include courses in general and organic chemistry, microbiology, physiology, biochemistry, advanced human nutrition, and courses on food service systems organization and food production management. Currently, Ontario has four undergraduate degree programs at the University of Western Ontario, the University of Guelph, Ryerson University and the University of Ottawa.

The practical training component of dietitians’ education consists of a minimum of 35 weeks of practical training under the supervision of a dietitian. The internships include rotations in clinical practice (including the role of nutrition in human disease states and the development of nutrition therapies), community practice (health promotion and disease prevention, including needs assessment, program planning, delivery and evaluation) and food service administration (management of food service systems and clinical nutrition services) plus an elective area of practice (such as research).

Internationally educated dietitians and graduates of non-accredited programs may have their education assessed for equivalency.

Entry to Practice

Upon completion of the university and internship components, dietitians must also pass the Canadian Dietetic Registration Examination (CDRE) which assesses their competence to practice in Canada. The exam is developed and administered by the Alliance of Canadian Dietetic Regulatory Bodies. It is a multiple-choice written examination testing practice-based knowledge, application and critical thinking skills. It is based on the Essential Competencies for Dietetic Practice in Canada, which express the minimum expected knowledge and skill for dietetic practice. These essential competencies inform the development of dietetic curriculum, internship programs, continuing competency requirements and the rules of professional conduct.

Quality Assurance

Once registered, dietitians must continue their professional development to remain current and expand competencies needed for delivering safe, ethical and high quality dietetics services.

The College’s mandatory Quality Assurance Program promotes continuous learning and competency development by its members. The goals of the program are to:

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9 According to the Association’s website, the program at University of Ottawa has yet to be accredited.
Chapter 4 – Review of the Scope of Practice of Dietetics

- Assist members to improve their individual competence,
- Identify and remediate members demonstrating a need for improvement,
- Evaluate members’ participation in the Quality Assurance Program,
- Evaluate the issues affecting the practice of dietetics and quality of service, and
- Evaluate the Quality Assurance Program to ensure it remains effective.

The components of this mandatory program are:

**Self-Assessment** – This component involves the use of the Self-Directed Learning Tool that guides members to evaluate their level of skill in the various components of their current practice using a rating scale (expert, developing, etc.), to identify challenges and barriers to practice, and to develop a professional improvement plan. This component also involves the use of the Jurisprudence Knowledge and Assessment Tool, through which members learn about the legal, regulatory and practice requirements that govern dietetic practice in Ontario.

**Practice Assessment** – Each year, the College randomly selects the names of members required to undergo a practice assessment. This process includes inspecting and reviewing the premises where the member practices, client records and the member’s self-assessment and professional development records. It may also include interviews with employers and peers and case simulations. The College is now determining the number of members who will be assessed each year as part of this component of the program.

**Remediation** – Where a member’s practice is found below standards through practice assessment and review of self-assessment exercises, remediation may be required to address gaps in knowledge or skill.

**What HPRAC Learned from Research**

In addition to carefully considering the evidence presented by the College and the Association, HPRAC undertook a review of the published literature, a jurisdictional review of the scope of practice of dietetics outside Ontario, and a jurisprudence review of the scope of practice of dietitians nationally. The literature and jurisdictional reviews are posted on the HPRAC website.

**Literature Review**

Highlights include considerable literature confirming that dietitians are trained and educated to provide expertise on food and nutrition. The literature also illustrated the variety of roles through which they accomplish this.

Nutrition and the nutritional status of patients is increasingly recognized as a major determinant of health status and outcomes. It is also clear that nutrition interventions early in the care plan greatly impact outcomes. Increasingly, dietitians are expected to determine nutrition requirements in both healthy and ill patients and are recognized for the unique body of knowledge that enables them to conduct comprehensive nutrition assessments and to recommend optimal nutrition therapy.

There is little published literature on the issue of scope of practice or enhanced scope of practice for dietitians. However, a few studies document the benefits of dietitians’ involvement in a number of areas
Chapter 4 – Review of the Scope of Practice of Dietetics

of care and for particular client groups.\textsuperscript{11} Some studies have attempted to capture data on the effect of dietetic interventions on patient outcomes in chronic disease populations such as diabetes patients.

Key findings in the literature support dietitians’ involvement in the prescription of nutrition therapy to ensure that optimal therapy is chosen, risks are minimized and costs are contained. Several case studies have been published on practice models in hospital settings where dietitians have the authority, through medical directives, to prescribe and manage nutrition therapy. In each of these cases, the collaborative nature of the process of prescribing and managing nutrition therapy is emphasized.

\textbf{Jurisdictional Review}

All Canadian and three international jurisdictions were examined.

The use of the term “dietitian” is standard across all jurisdictions reviewed, and the assessment of nutritional needs and the dissemination of information about food are central to the role of dietitians across most jurisdictions.

Among Canadian jurisdictions, Alberta and British Columbia have the most comprehensive legislation, which makes references to designing and implementing nutrition strategies and therapeutic diets. In British Columbia, qualified dietitians are permitted to “design, compound or dispense” therapeutic diets if nutrition is administered through enteral means, and “design” therapeutic diets if nutrition is administered through parental means. Qualified dietitians in Alberta are permitted to insert and remove nasoenteric tubes, prescribe certain drugs and parenteral nutrition, provide enteral nutrition and perform psychosocial interventions. All other provinces and territories have little or no legislation addressing what dietitians can and cannot do.

\textbf{Perspectives from the Consultations}

The submission was the outcome of a collaborative process involving the College and Dietitians of Canada as well as a range of dietitians and others with an interest in the subject from all parts of the province.

HPRAC’s consultation program was designed to gain additional information, perspectives and understanding of the issues, benefits and risks associated with any changes to the scope of practice for dietitians in Ontario. As part of the consultations, HPRAC held broad local health provider roundtables in five communities, met with other regulators and professional associations, and conducted a number of key informant interviews. A separate meeting was also arranged with key educators.

HPRAC received more than 35 written responses to the review of the scope of practice for dietetics. A number of letters of support were received from individual dietitians, and other dietetic organizations and associations. In addition, HPRAC received submissions from other health care providers, health regulatory colleges and associations. Some indicated their support, others raised issues and concerns, and some did both with respect to the proposals. HPRAC has considered these responses in its analysis and recommendations. All of the responses are available on HPRAC’s website.

Chapter 4 – Review of the Scope of Practice of Dietetics

The key points emerging from the roundtable consultations on the dietetics scope of practice referral are summarized under three main categories: System Needs, Scope of Practice and Competency.

System Needs

Participants in the roundtable discussions said that a number of system issues prevented dietitians from working to their full scope of practice. Several dietitians said that their profession did not receive its due recognition among others in the health care sector. As with other allied health professions, the profession of dietetics has grown and matured in the past decade or more. Dietitians now work in a broad range of settings such as hospitals, medical clinics, long-term care homes and home care. The onset of diabetes in greater numbers and the problem of obesity, particularly in children, have brought dietitians to the forefront in handling various aspects of these issues. Their role is key, particularly at the primary health care level.

Like other health professionals, dietitians believe that too often the system of medical directives and delegation acts as a barrier to efficient and effective care. Many complaints were heard about chasing physicians to get orders signed when the dietitian was often the one who knew best what to order. HPRAC was told that a number of hospitals have well balanced interdisciplinary nutrition support teams including physicians, physiotherapists, pharmacists, nurses, nurse practitioners and dietitians.

Hospitals are increasingly using dietitians as part of multifaceted interprofessional care teams. This is particularly clear in the field of enteral and parenteral nutrition. Physicians, nurses, nurse practitioners and pharmacists work with dietitians in prescribing and managing enteral and parenteral nutrition. Dietitians would like to be placed more at the centre of this interprofessional team.

The Local Health Integration Networks (LHINs), community care access centres and long-term care home operators all noted that they could make greater use of dietitians. An issue raised by all was how funding models often make it difficult to bring a dietitian on board. In many instances a dietitian is working for a day or part of a day each week in one setting. It was reported that it can be difficult for dietitians to find full time employment although their services could be utilized on a full time basis. The Ontario Ministry of Health and Long-Term Care currently funds 15 minutes per resident per month for nutritional care in a long-term care home.

WHAT HPRAC HEARD ABOUT…SYSTEM NEEDS

“Physicians often would rather that the dietitian managed a resident's diet, because physicians don't work with diets all the time and they have too many other things to look after. If you build a trust relationship with the physician that you are working with, most of the time they will be willing to write a ‘blanket order’, for example ‘Follow the dietitian's orders regarding resident's tube feeding.’ We take over from there.

What happens in practice in a long-term care facility is that if dietitians are not authorized to change tube-feeding orders as needed, but only to make recommendations for change, the resident may end up being hospitalized.”

Lucy Brundage, Clinical Dietitian
City of Thunder Bay Homes for the Aged (Dawson Court)
Thunder Bay, Ontario
“The reason that patients may not be aware of their diagnosis is twofold. One is a little bit of denial on the patient’s part. The second reason could be that the physician ordered a lab test for their annual blood work and sent the result directly to the dietitian and booked the appointment with the dietitian before seeing the patient because there is a wait list for the dietitian as well. If the wait list for the dietitian is shorter than the physician’s list, then the patient would see the dietitian first without the diagnosis from the physician.”

Craig Orrell, Dietitian, Timmins Family Health Team, Timmins, Ontario

“If you look at the way the hierarchy has evolved and the system has evolved, a lot of it has evolved for a number of reasons, but one of them is that you get multiple different eyes on an order. There is a higher chance that an error will be caught. Not all errors will be caught. The idea is to prevent errors, prevent adverse reactions and to prevent people being harmed from medication errors and other errors. If we start to only look at how quickly we can accomplish something without other eyes and expertise involved, we may end up with more problems.”

Merrilee Fullerton, Family Physician, Ottawa, Ontario

Scope of Practice

The dietitians said that the proposed change to their scope of practice statement will more effectively recognize their increased role as a health professional in population health, nutrition therapy, food systems management and health promotion. It was frequently noted by dietitians that patients would arrive at a dietitian’s office without actually knowing their diagnosis. This was especially true for cases of diabetes. The physician, in some cases, would order a test, review the results and send a patient directly to a dietitian before meeting with the patient to discuss a diagnosis. This, HPRAC was told, can result in lengthy delays, since the dietitian is forced to send the patient back to the physician to learn about the diagnosis before the patient can return to the dietitian and be placed on a proper program of care.

Dietitians also said that while they are involved in diabetes education (many are Certified Diabetes Educators), they are not allowed to demonstrate how to inject insulin directly on a patient. Nor can they make adjustments to insulin or oral hypoglycemic medications unless under a medical directive. Many dietitians said that they should be able to perform these controlled acts independently. A number of the participants also argued that there is a risk of harm to the public with enteral and parenteral nutrition. They said that the prescribing and managing of these two procedures should be made a controlled act authorized to dietitians. Similar arguments were made about the prescribing and managing of therapeutic diets. These activities are currently handled through medical directives or orders.

WHAT HPRAC HEARD ABOUT…SCOPE OF PRACTICE

“In relation to blood glucose testing, we are developing more home monitoring tests. I wonder if there were complaints brought to the College of Dietitians about dietitians that did glucose checks using home monitoring devices. Tests that can be done at home by a patient should be able to be done in a health professional’s office by a patient.”

Lee Donohue, Family Physician, Family Health Group, Ottawa, Ontario
Competency

HPRAC met with a number of educators to review university and post-graduate programs available for prospective dietitians. The educators thought that the current programs and the one-year internship covered most of the educational needs for what the College was proposing. There were reservations about whether some of the new procedures would require an extended level of training. It was noted that not all dietitians would want to be involved independently in a total parenteral nutrition program without advanced training. A major point raised was the number of internships available to graduates. A high percentage of graduates cannot find an internship placement and, because of registration requirements, cannot be registered as a member of the College.

At a meeting held with other key health regulatory colleges and associations most closely linked with dietetics, a number of questions were raised about the need for new controlled acts. While recognizing the evolving role of the dietitian, some participants thought that role would be better expressed within an interprofessional collaborative environment.

WHAT HPRAC HEARD ABOUT…COMPETENCY

“Dietitians have gained the respect of physicians to the point that they will prefer us to process nutrition recommendations and see it as an inefficiency when they have to rewrite our recommendations.”

Cindy Dodsworth, Dietitian, Tilbury District Health Team, Tilbury, Ontario

“The intensivists have a lot of trust in the ICU multidisciplinary team we have created, which are mainly the pharmacists, dietitians, respiratory therapists and nursing staff. We consult on a daily basis on enteral and parenteral nutrition therapies. No one ever does anything by themselves. The pharmacists are always involved in parenteral nutrition therapy and to a lesser extent, enteral nutrition. I never write a recommendation for parenteral nutrition without consulting a pharmacist first.”

Cara Jacobson, Clinical Dietitian, TBRMSC, Thunder Bay, Ontario

“With expanding scope of practice, there needs to be enhancement to the communication process between the multidisciplinary players. I have mixed feelings for adjusting oral hypoglycaemic drugs. Initiating the medication is not the intention but the adjusting is. There are several oral hypoglycaemics which impact other systems. There is a great debate on a few drugs which impact on heart function. That is quite complex for me as a dietitian.”

Joanne Guizzo, Dietitian, HRSRH
Outpatient Nutrition Counselling and Diabetes Education Care Program, Sudbury, Ontario
HPRAC’s Observations

The submission by the College and the Association described numerous frustrations experienced by dietitians in their daily practice as experts in food and nutrition. It provided further evidence of the need to enhance opportunities for, and development of mechanisms to support interprofessional collaboration. Only then will the full potential of all members of the health care team be utilized, and outcomes for patients optimized. HPRAC looks forward to providing further recommendations on such mechanisms for interprofessional collaboration in its final report to the Minister in 2009.

Professional knowledge, common practices and health professions have evolved since the inception of the RHPA. The literature documents a growing understanding of the role of nutrition in health care as well as the impact of nutrition status on the treatment of a variety of patient conditions. It also recognizes the expertise of dietitians who are uniquely qualified to assess nutrition risk, analyze nutrient intake, maximize nutritional status through the provision of nutrition support in the form of therapeutic diets or enteral and parenteral nutrition, and monitor and adjust those interventions in the interests of the patient. They are also key expert resources in the management of chronic diseases due to their detailed knowledge of the interplay of nutrition and activity on various diseases, such as diabetes, and conditions, such as a high risk pregnancy.

The challenge has been to determine, from the several barriers identified by the College and the Association, which ones should be reduced through legislative and regulatory change and which ones require structural changes and new ways to integrate dietitians in interprofessional care delivery. Substantive concerns were raised with the dietitians’ proposals, in particular concerning the request for new controlled acts and the authority to manage medications. However, participants were unanimous in acknowledging the contributions of dietitians in providing nutritional support in health care across all settings and populations. HPRAC is proposing some legislative changes to enhance dietitians’ ability to practise to the full extent of their competencies. In the end, HPRAC finds that greater efforts to develop interprofessional collaborative arrangements and processes will maximize the benefits derived from dietitians’ participation in patient care.

The RHPA and the Profession-Specific Acts – Scope of Practice Statements

The College has requested a change to the scope of practice statement in the Dietetics Act, 1991 to reflect the additional activities that it is requesting, including access to new controlled acts. The scope of practice statement found in each profession-specific Act under the RHPA provides a frame of reference for the performance by regulated health professionals of their authorized acts. Regulated health professionals may perform their profession’s authorized acts only in the course of practising within the profession’s scope of practice.

In the context of the scope of practice reviews, HPRAC would consider amending a scope of practice statement only in the following situations:

- When an act is added to the list of authorized acts conferred upon a health profession, and
- When HPRAC is satisfied that its criteria for a scope of practice review have been met.

This analysis would take place at the same time as HPRAC considers the expansion of a health profession’s authorized acts. That is, HPRAC will ask: does an expanded scope of practice statement encompass a new assessment, diagnostic, treatment or prevention opportunity for the profession that was previously prohibited? Is this expansion necessary and/or desirable?
As HPRAC has stated in its document, *The Review of a Professional Scope of Practice*, under the *RHPA* a scope of practice includes many elements, one of which is the scope of practice statement. Based on the various elements that determine whether a scope of practice statement should be amended, HPRAC will provide the analysis and recommendations on the scope of practice statement after it has determined whether dietitians should be granted access to the additional controlled acts being proposed.

Only after consideration of all of the specific controlled acts being proposed by the College and the Association will it be clear how, and to what extent, the scope of practice statement needs to be amended.

**Access to Existing Controlled Acts**

**Communicating a Diagnosis**

The College and the Association request that dietitians be given the authority to “communicate a diagnosis that relates to nutrition therapy only when the diagnosis has been confirmed by a physician, nurse practitioner or other authorized healthcare provider.”\(^{12}\) The rationale for this request is that patients are frequently referred to a dietitian without any knowledge of a diagnosis or the reason for the referral. Dietitians said that they are often in a situation where they cannot develop a nutrition plan without explaining to the patient the diagnosis that makes it necessary. Furthermore, they are unable to obtain informed consent or secure compliance on the part of the patient if the patient is unaware of the diagnosis. By example, dietitians describe a patient with diabetes who has no knowledge of the presence of disease and is unlikely to consent to a nutrition care plan or comply with a dietitian’s recommendations, unless fully aware of having a disease that requires management.

While dietitians are authorized to conduct nutritional assessments and communicate the results of those assessments, they contend that if the assessment indicates the presence of disease or another medical condition, they are obligated to refer to a physician who can confirm the diagnosis. They contend that patients are unlikely to comply with treatment if they are told it is to “lower their blood sugar”, but they will likely comply if they are told it is because they have diabetes.

Dietitians expressed frustration with having to either refer patients back to the referring professional, or attempt to locate the referring professional to determine how best to handle such situations. They said that time and effort could be spared if they were able to communicate a diagnosis so they can then deal with the nutritional implications of the diagnosis with their patients.

HPRAC has previously concluded that, “the performance of the controlled act [of communicating a diagnosis] would require the authorized professional to have the competencies to make a diagnosis, or to validate with some confidence a diagnosis made by another health professional”.\(^{13}\) Furthermore, HPRAC has said that, “to label or validate with some confidence the disease or disorder causing the symptoms, health professionals communicating a diagnosis to someone who is going to rely on this information must engage themselves in the cognitive process of reviewing the assessment findings and drawing a conclusion based on the body of knowledge and science of their profession.”\(^{14}\)


In reviewing this matter, HPRAC has concluded that dietitians do not have the competencies to validate a diagnosis made by another professional when a patient has been referred for the purpose of receiving care.

HPRAC is concerned that dietitians will delay their own professional assessments and treatment plans while waiting for the referring professional to communicate a diagnosis to a patient. As dietitians have pointed out, this does not reflect best care and is not in the best interests of the patient.

Dietitians can communicate the results of an assessment within their scope of practice. There are no restrictions in the *RHPA* on a dietitian making an assessment of the patient’s physical signs and symptoms, communicating the results of the assessment to the patient, and subsequently commencing a course of treatment with the patient’s consent. In the course of making a nutritional assessment, which is the expertise of the dietitian, information will be gathered that will lead to a clinical judgment and a determination of the appropriate course of treatment, which can be conveyed to the patient. These steps would be taken whether or not the patient is aware of a diagnosis, which may be simple or multidimensional. Treatment of the matters within the competence of the dietitian should not be delayed as a result of the dilatory performance of another professional.

HPRAC views the request to communicate a diagnosis that has been confirmed by an authorized provider as a request to be a “messenger” on behalf of the professional who made the diagnosis. This is contrary to what is intended by making “communicating a diagnosis” a controlled act.

The obstacles identified by the College and the Association that gave rise to this request are significant, and HPRAC believes they should not be underestimated. They speak to an urgent need to address proper referral practices by all health professions to protect the public interest and ensure safe, timely and coordinated patient care. It is clear from the examples raised in the consultations with dietitians that they believe they are impeded in providing their professional expertise because of shortcomings of other professionals. This is disrespectful and not in the best interests of patients, who have a right to hear the diagnosis in order to understand it, make decisions and provide consent to treatment.

**Recommendations:**

1. That no change is required to the *Dietetics Act, 1991* concerning the controlled act of communicating a diagnosis.

2. That an early dialogue take place between the College of Dietitians of Ontario and the College of Physicians and Surgeons of Ontario to establish, for both professions, guidelines on referral and reporting practices to and from the professions, and that those be communicated to members of both professions.

**Procedure Below the Dermis**

While dietitians are knowledgeable in the nutritional implications of diabetes, among other diseases and conditions, and some are certified as diabetes educators through the Canadian Diabetes Association, they are currently unable to perform skin pricks for the purpose of obtaining capillary blood readings critical to the monitoring of such conditions. This act falls within the controlled act of performing a procedure below the dermis, which is not authorized to dietitians.
The *RHPA* provides exceptions for routine activities of daily living\(^\text{15}\), but there are instances where collecting blood samples is required more frequently. The College and the Association say that “registered dietitians need blood glucose readings in order to accurately evaluate the patient’s response to prescribed diet therapy, to assess the need to implement treatment for hypoglycemia and to develop appropriate meal plans and nutrition interventions.”\(^\text{16}\)

HPRAC agrees that dietitians need this tool to provide patient care. The use of capillary blood readings to monitor lipid levels is also emerging, and authorizing this act will position dietitians to benefit further from this method of monitoring their patients in the future.

**Recommendation:**

3. That registered dietitians be authorized to take blood samples by skin pricking for the purpose of monitoring capillary blood levels.

**Adjusting Drug Prescriptions**

The College and the Association requested that dietitians be authorized to adjust existing insulin or oral hypoglycemic medications in response to patients’ nutritional status.

HPRAC has determined through its review of the profession of pharmacy that altering a drug dose or the timing of a dose from the original prescription is in fact prescribing, and therefore requires the knowledge and competencies of a professional authorized to prescribe. These activities also impose accountabilities on the prescriber, who is subject to the controlled act.

Prescribing a drug implies knowledge beyond the basic pharmacology, physiology and clinical nutrition education taught in entry to practice dietetic education.

Diabetes management requires a detailed knowledge of the interplay between nutrition, activity and blood glucose levels. Dietitians have detailed knowledge of the science of nutrition as well as skill in assessing and monitoring nutrition status. This positions them as experts in the management of diabetes and other chronic diseases and conditions. Through the Canadian Diabetes Association’s Certified Diabetes Educator (CDE) program, dietitians and other health professionals can obtain further education and training on the management of diabetes. Currently, 24 percent of College members list diabetes care as part of their practice and of those, 42 percent have CDE certification or are working towards it.\(^\text{17}\) The College told HPRAC that CDE certification alone is not sufficient to obtain competencies to adjust insulin or medications and that further post-graduate education would be required to augment the foundational knowledge of insulin and pharmacology obtained in entry to practice curricula.

Discussions with representatives of dietetics educational programs in Ontario revealed their concern that, while the curricula teaches the use of and the actions of insulin and oral hypoglycemic medications, far more experience and expertise would be needed to adjust prescriptions for individual clients. Before performing these activities independently, dietitians would require opportunities to obtain and

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\(^{15}\) *Regulated Health Professions Act, 1991. s.30(5)(e).*

\(^{16}\) College/Association submission, p.23.

\(^{17}\) College of Dietitians of Ontario. Registration statistics as obtained from College Registrar.
demonstrate the appropriate knowledge, skills and judgment to adjust insulin and medications for clients and to have these actions properly evaluated.

In its review, HPRAC was concerned that the request referred to “insulin or oral hypoglycemic drugs” as if they were similar agents with similar actions. HPRAC learned through consultation with a subject expert in pharmacology that these are two different agents with different sets of risk to patients. Whereas insulin is primarily injected as part of maintenance hypoglycemic therapy or in response to changes in glucose levels, oral hypoglycemic agents, as implied by their description, are ingested orally in tablet or capsule form. Oral hypoglycemic agents are used by type II diabetics to increase pancreatic release of insulin, enhance tissue sensitivity to insulin, or to decrease glucose absorption from the gastrointestinal tract. People who take insulin and many health care practitioners, including dietitians, are familiar with the potential adverse effects of insulin with respect to glucose metabolism – that is, with the risk that glucose levels could drop dangerously low.

There are additional risks of harm related to the altering or prescribing of oral hypoglycemic medications. First, many of these medications have potential adverse effects not limited to their impact on glucose levels and metabolism. Second, many patients who would be taking oral hypoglycemic medications are also taking other medications. Several oral hypoglycemic agents interact with other pharmaceutical agents. In fact, 10 of the top 100 drug interactions involve oral hypoglycemic agents. Although these drug interactions should be identified when the initial prescription is written, the risk of harm due to adverse effects and drug interactions relating to oral hypoglycemic medications is substantial. Changes to such prescriptions should not be made by dietitians in the absence of the expertise of other health professionals such as physicians, nurse practitioners, or pharmacists.

Both insulin and oral hypoglycemic medications are classified as “high alert medications” by the Institute of Safe Medication Practices. Such classification implies that these substances “bear a heightened risk of causing significant patient harm when they are used in error.”

HPRAC accepts that dietitians working in Diabetes Education Centres and other settings, “regularly instruct clients on how to adjust their insulin based on meal intake, activity level, and self blood glucose monitoring results.” However, as the College’s position statement on insulin adjustments states, “teaching the client how to calculate a change in insulin requirement and making suggestions and recommendations for insulin adjustments…is distinct and different from prescribing a specific dose of insulin”. The same standard states that, when working with diabetes patients, dietitians should “differentiate between specifying the dose versus teaching self-management.” It is for this reason that changing or adjusting insulin or oral hypoglycemic medications must be done by, or in consultation with, the authorized prescriber.

According to the College and the Association, many dietitians are currently authorized to order or prescribe various medications through medical directive or other mechanisms. HPRAC has concluded that this prescription adjustment activity is properly suited to delegation from an authorized provider or prescriber who has complete knowledge of the patient, his or her medication history, other conditions and other relevant information. The acceptance of the delegation implies that the individual accepting the delegation has the competencies to perform the act. HPRAC emphasizes the continuing obligation of the College to enforce standards of practice on delegation and the receipt of delegation.

20 College/Association submission, p.24.
The Canadian Diabetes Association (CDA) has published extensive clinical best practice guidelines for diabetes management and acknowledges that the field of diabetes care and management is rapidly changing.\textsuperscript{22} The CDA recommends frequent monitoring and adjusting of insulin or medications and the guidelines cover the use of different insulin agents and oral hypoglycemic medications, their indications and contraindications, and recommended targets for glycemic control. Such resources are of great use to dietitians and all professionals who care for patients with diabetes.

**Recommendation:**

4. That dietitians not be authorized the controlled act of prescribing or dispensing specifically for the adjustment of insulin or oral hypoglycemic regimens.

**Psychotherapy**

The College and the Association have said they are uncertain whether some of the activities that dietitians perform might be considered psychotherapy. If these activities are in fact psychotherapy, this might limit the services dietitians provide to patients. The College and the Association raise this to signal a new regulatory concern, and seem to be seeking a direction to approach the College of Psychotherapists and Mental Health Therapists of Ontario when it is established.

They say that dietitians often engage in psychotherapeutic interventions when providing nutrition counselling, particularly when dealing with patients who suffer from addiction or eating disorders such as anorexia nervosa. Dietitians are central to the care of such patients to help them meet their nutritional needs and provide counselling to help them establish healthy eating habits.

In its recent review of the regulation of psychotherapists and psychotherapy,\textsuperscript{23} HPRAC scrutinized all regulated health professions in Ontario to determine whether the professional services they provided could be categorized as providing psychotherapy, as distinct from counselling. It identified existing regulatory colleges whose members provide psychotherapy as the College of Physicians and Surgeons of Ontario, the College of Psychology of Ontario, the Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario. At that time HPRAC concluded that dietitians’ counselling services do not meet essential definitions required for designation as psychotherapy.

In HPRAC’s view, if the work of a registered dietitian is substantially that of a psychotherapist, then that member should become a dual registrant in the College of Dietitians of Ontario and the College of Psychotherapists and Registered Mental Health Therapists of Ontario. The College should also issue a guideline to its members on this matter.

**Recommendation:**

5. That dietitians not be authorized to perform the controlled act of psychotherapy.


\textsuperscript{23} New Directions, A Report to the Minister of Health and Long-Term Care and Regulatory Issues and Matters respecting Health Care Practitioners, Patients and Clients, Health Professions Regulatory Advisory Council, pp. 206-228.
New Controlled Acts

The College and the Association have recommended the creation of two new controlled acts for prescribing and managing enteral and parenteral nutrition, and prescribing and managing therapeutic diets. HPRAC dealt with these proposals as a single request, as both are forms of nutrition therapy, often referred to as medical nutrition therapy.

The rationale for the creation of the new controlled acts is that there is substantial risk of harm to patients if these interventions or modalities are performed by individuals without extensive knowledge of nutrition therapy. The submission did not explicitly request that these controlled acts be authorized exclusively to dietitians. However, it implied that the educational preparation of dietitians uniquely positions them as the most appropriate health professional to prescribe and manage nutritional therapy and, more specifically, to provide a coordinating and management function when these acts are performed in collaborative nutrition support teams. As well, the submission did not provide evidence that patients in Ontario are receiving enteral or parenteral care in the absence of professionals with expertise in the prescribing, design, formulation or delivery of enteral or parenteral solutions.

Enteral and parenteral nutrition are common technologies used to feed individuals through artificial means when their normal capacity to take in food and nutrients is compromised and to treat or prevent malnutrition. Enteral nutrition provides nutrition through a tube inserted into the gastrointestinal tract and parenteral nutrition provides nutrients intravenously. Parenteral nutrition, or total parenteral nutrition, is used when patients are unable to meet their nutrition requirements with either an oral diet or by enteral means, or when their gastrointestinal tract is not functioning.

Dietitians working in hospital or long-term care settings are frequently involved in the care of patients requiring enteral nutrition. While parenteral nutrition is most likely limited to hospital settings, the use of total parenteral nutrition in the home setting is emerging in infrequent circumstances.

There are risks involved in enteral and parenteral nutrition, as with most medical interventions, and these are particularly complex. Potential complications of enteral nutrition include:

- Gastrointestinal intolerance due to inappropriate formula selection, rate of administration or possibly mode of administration,
- Tube clogging due to the selection of a formula that is too viscous for the size of the feeding tube or inadequate flushing of the tube,
- Malnutrition due to inadequate calories, protein and other essential nutrients,
- Over-nutrition due to provision of excessive or imbalanced amounts of nutrients and/or energy,
- Aspiration due to inappropriate placement of the feeding tube, and
- Re-feeding syndrome due to a failure to properly regulate the rate of nutrition support.

Possible complications of parenteral nutrition include:

- Venous complications due to inappropriate selection of formula, infections or blood clots,
- Malnutrition due to inadequate calories, proteins and other essential nutrients,
- Over-nutrition due to additional carbohydrates and calories, particularly dextrose,
- Liver complications including elevated levels of triglycerides and damage to liver cells, and
- Re-feeding syndrome.\(^{24}\)

\(^{24}\) College/Association submission, p.54.
Therapeutic diets, on the other hand, are prescribed to manage, control or ameliorate diseases, to meet energy requirements for optimal growth, to supplement regular diets with specialized products (e.g. Ensure), or to alter food textures and fluid consistency to improve nutrient intake. Therapeutic diets are not the same as nutritional or diet advice because they are customized to individual patients and may be either adjunct therapies to other medical interventions, or the sole method of treating a particular condition.

Therapeutic diets involving supplements or exclusion of food groups may carry a significant risk of harm when they are used inappropriately in the treatment for a medical condition.\(^{25}\) They depend on evidence-based nutrition guidelines for defined conditions. They must support optimal patient medical and nutrition outcomes and decrease the risk of harm associated with alternative therapeutic diets.\(^{26}\)

HPRAC learned that the prescription of enteral and parenteral nutrition is a highly collaborative process, and this is supported in literature reviews and in published standards of practice for nutrition support dietitians.\(^{27,28}\) Nutrition support teams include dietitians, pharmacists, nurses and physicians. Delivering nutritional care to patients is a complex process that relies on the multi-disciplinary expertise of these professionals, and their working together as a team. It is essential to establish protocols for all steps in the process and to coordinate those steps: assessing patient needs, determining the appropriate therapy, deciding the form and content of nutrition, formulating and adjusting the nutrients, and extensive patient monitoring. Understanding and managing risks and ensuring patient safety are critical. Many of the individual nutrients in a parenteral formula are unsafe when not prescribed or formulated appropriately, and there is a delicate balance in the prescribing, formulating, compounding and administration of parenteral solutions.

HPRAC heard that there are systematic steps in the management of enteral and parenteral nutrition. Each step recognizes and depends on the expertise of those involved in the next or previous step. Each step is patient-specific. As leader of the team, the health care provider who has made a diagnosis normally orders or prescribes treatment for the patient. Dietitians conduct the nutritional assessment of the patient to determine the solution to be administered and recommend the appropriate formula. Pharmacists compound the prescription and, if there is a pre-mixed formula, the pharmacist may add micronutrients and drug additives prescribed by a physician. Nurses initiate the intravenous or gastrointestinal lines and monitor the feeding tubes, and dietitians monitor the patient’s response to the treatment by routinely assessing changes in nutritional status. Based on monitoring results, dietitians may recommend changes to the formula. Often, several adjustments are required in the early stages of the treatment to ensure the patient responds appropriately.

Accreditation standards for hospitals as well as other institution-specific policies and protocols outline the requirements for the safe prescription and administration of nutrition therapy. These standards include medication orders, assessments, precautions, prescription reviews, allergies and interactions, dose range checks, aseptic techniques, admixture areas, patient monitoring and quality control.\(^{29}\) It is clear that there is demanding oversight and exacting standards, not only for the practice setting but for the professionals who provide care and are accountable for the performance and delegation of controlled acts.

The literature review found several studies documenting the positive impact on patient outcomes, timeliness of care, and productivity of other health care providers resulting from dietitians’ involvement

\(^{25}\) Ibid, p.59.
\(^{26}\) Ibid, p.60.
\(^{27}\) American Society of Enteral and Parenteral Nutrition. “What is a nutrition support professional?” See www.nutritioncare.org
\(^{29}\) Accreditation Canada, CCHSA’s Accreditation Program 2008; Standards, Managing Medications.
in enteral and parenteral nutrition and therapeutic diets. Studies show that patient outcomes improve when dietitians’ recommendations are followed and that dietitians bring expert knowledge to the interdisciplinary team. HPRAC supports the role of the dietitian in nutrition therapy as a significant contributor to any nutritional support team.

HPRAC is impressed with the shared responsibility and team-based care that marks patient nutritional support. There is no single professional who can be uniquely identified as the essential participant in this process. Rather, the skills, experience and combination of numerous professional experts and specialists strengthens HPRAC’s confidence in interprofessional collaboration. During its consultations, HPRAC noted the emphasis placed on coordination and cooperation in nutrition services to ensure that patients received the best possible care. HPRAC has concluded that authorizing new controlled acts could fundamentally alter what is generally a working collaborative model of providing clinical care – a model where the expertise of each profession on the team is recognized.

However, when one part of a team expresses such deep concerns, there are matters that need to be addressed. They cannot be addressed, nor should there be an expectation that they can be addressed, by changes to legislation or regulation. The Ontario Hospital Association, along with representatives of professions who are involved in prescribing or providing nutritional therapy, should jointly engage in discussing these process matters. Their recommendations could become a guide for hospital boards, administrators and professional staff, as well as for the College.

HPRAC is not convinced of the need for new controlled acts for these therapeutic modalities.

**Recommendation:**

6. That the creation of two new controlled acts for the prescription and management of enteral and parenteral nutrition and the prescription and management of therapeutic diets is not required.

**Scope of Practice Statement**

The College and the Association have recommended that the scope of practice statement for dietitians be amended to read:

Dietetics is the assessment of nutrition related to health status and conditions for individuals and populations, the management and delivery of nutrition therapy to treat disease, the management of food systems, and building the capacity of individuals and populations to promote or restore health and prevent disease through nutrition and related means.

They say that this change would “better reflect dietitians’ involvement in population health, nutrition therapy, food systems management, and health promotion”, rather than reflecting only the clinical sector of the profession that the current scope of practice statement describes.

The scope of practice statement serves to provide the parameters within which a regulated health professional can exercise his or her authority to perform controlled acts. HPRAC holds that scope of

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practice statements need to be amended only if additional controlled acts are being authorized to the profession, and if those acts alter or expand the role of the profession.

The proposal requested the inclusion of other than clinical aspects of dietetic practice in the scope of practice statement. In its analysis, HPRAC found that references to “food systems management”, “health promotion” or “population health” are not directly related to a controlled act as set out in the RHPA. These are public domain activities and, in some cases, they are unrelated to patient care. These activities do not qualify for inclusion in the profession-specific Act.

HPRAC has concluded that the current scope of practice statement sufficiently describes the parameters for dietitians’ practice in Ontario and provides satisfactory clarity for members, other providers and the public as to the role of dietetics in patient care.

**Recommendation:**

7. **That no change be made to the scope of practice statement for dietitians.**

**Amendments to Related Legislation**

**Public Hospitals Act**

The College and the Association tell of the dissatisfaction of many dietitians with the recognition of their expertise in various practice settings, particularly in the area of nutrition therapy. This prompted the request to amend the Hospital Management Regulation made under the Public Hospitals Act to permit dietitians to independently order tests and treatments relevant to nutrition assessment, rather than rely on medical directives or delegation.

**Medical Directives**

Medical directives are physician instructions relating to the care and medical treatment of a specific patient population. They define the agreement of physicians on best practice for medical interventions, and how other health professionals should be involved in carrying out treatment protocols. They contain the delegation and authority for identified health care professionals to carry out treatment protocols when patients meet established criteria. They are written in accordance with evidence-based practice standards. These are not simple documents. Their development requires significant consultation and agreement among physicians and other professionals who provide patient services in hospitals and other health care settings. Because many of the procedures for which they are written are complex, they may take months or years to prepare. They are usually relevant to a particular practice setting and to specific professionals who work in that setting.

HPRAC has heard numerous comments and opinions about the effectiveness, development and implementation of medical directives, which have been cited as barriers to collaborative practice by many health professionals. Many say that medical directives impede collaboration because the interaction between professions occurs only when the directives are developed and there is no encouragement of collaboration in actual patient care. Some feel shut out of the process when the directives are developed, and resent that others have determined their role. Some say that the protocols in medical directives are so
difficult to develop and be approved that what was seen as state-of-the-art at the time quickly becomes out of date. Others say that medical directives provide direction for best practice and care.

The complex processes surrounding medical directives evolved as unintended consequences of the RHPA. Medical directives were intended to be a mechanism to promote team-based care through physician leadership and the delegation of authority to other professionals. Medical directives, by their nature are hierarchical. The physician is accountable for the performance of the team. Professional silos, it was thought, would be reduced by recognizing the skills and knowledge of all team members, and by institutionalizing best practices in clinical care and in processes. Most often, authority of the physician would be transferred to other health professionals, some with greater expertise than the physician but without controlled act authorization, in order to provide appropriate patient care. HPRAC is firmly convinced that the benefits and challenges of medical directives, and mechanisms to improve their development, implementation and evaluation, should be further explored.

Ordering Laboratory Tests

The submission of the College and the Association, consultations and the literature review confirmed dietitians’ proficiency in conducting detailed nutritional assessments. The *Essential Competencies for Dietetic Practice in Canada* include the ability to assess client nutrition status through physical observation and bodily measurements (weight, BMI, etc.) as well as through the interpretation of laboratory data related to nutrition care. Laboratory tests provide the metabolic data required to inform a comprehensive nutrition assessment. Entry to practice curricula teach students about the use of these tests to obtain critical data.

Currently, dietitians order laboratory tests to support nutritional assessments under medical directive or delegation. The rationale for the request to authorize dietitians to independently order such tests is that the current system of medical directives and delegation is cumbersome and untimely and results in inconsistent use of dietitians’ expertise across practice settings. Dietitians indicate that the process of obtaining an order for a test is an impediment to timely nutrition intervention, because it delays test results and the development or adjustment of treatment plans. From a practice perspective, dietitians told HPRAC that a patient on enteral or parenteral nutrition requires extensive monitoring, particularly in the early stages of the treatment, so that adjustments to the formula can be made accordingly. The monitoring function, central to dietitians’ expertise, depends on timely access to data obtained through laboratory tests.

While concerns were raised about the risk of duplication of tests and the increased burden on the system, HPRAC is confident that dietitians would use appropriate judgment in the use of such tests. Moreover, hospital patient records would document the test orders and results and HPRAC has no doubt that, outside the hospital, dietitians would record and report test information to other health professionals involved in a patient’s care.

**Recommendation:**

8. That section 24 of the Hospital Management Regulation made under the *Public Hospitals Act* be amended to authorize dietitians to order specified laboratory tests relative to nutritional assessment and monitoring.

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Laboratory and Specimen Collection Centre Licensing Act

Following the above rationale for recommending dietitians’ access to appropriate laboratory tests under the Public Hospitals Act, further regulatory amendments are required.

Recommendation:

9. That Regulation 682 and Regulation 683 made under the Laboratory and Specimen Collection Centre Licensing Act, 1991 be amended to allow dietitians to order specified laboratory tests relevant to nutritional assessment and monitoring outside the hospital setting.

10. That the College work with the College of Medical Laboratory Technologists of Ontario, the College of Physicians and Surgeons of Ontario and others, as required, to develop a list of appropriate laboratory tests related to nutritional assessment that could be ordered by dietitians.

Health Care Consent Act, 1996

The College and the Association requested that dietitians be included among the list of professionals who are able to act as evaluators when determining incapacity of an individual for the purposes of admission to a care facility. Currently, social workers, audiologists and speech language pathologists, nurses, occupational therapists, physicians, physiotherapists and psychologists may determine a person’s capacity with respect to admission to a care facility and with respect to personal assistance services.  

During HPRAC’s consultations, representatives of CCACs and long-term care facilities told of the need for more resources to facilitate case management in long-term care. It is HPRAC’s understanding that the Association has already been involved in discussions with the relevant stakeholders in this regard.

Recommendation:

11. That dietitians be added to the list of health professionals authorized as evaluators under the Health Care Consent Act, 1996.

Long-Term Care Homes Act, 2007

The College and the Association propose that, as regulations are developed under this new legislation, dietitians be authorized to order and manage nutritional care, including therapeutic diet orders and enteral and parenteral nutrition.

HPRAC has made recommendations above regarding the ordering and managing of enteral and parenteral nutrition and therapeutic diet orders. It is further recommended that as regulations are being developed, the Minister consider the needs of residents in long-term care homes for nutrition therapy and the resources available to ensure that those needs are met. As HPRAC has indicated for hospital settings, enteral and parenteral nutrition and therapeutic diet orders are suited to collaborative decision-making.

32 Health Care Consent Act, 1996. s.2(1); O.Reg. 104/96
Protocols for the effective and efficient ordering and management of such treatments are required in the long-term care setting as well.

**Conclusion**

HPRAC appreciates the time and effort spent by the College and the Association in preparing the submission, as well as their participation throughout the consultation process. HPRAC recognizes the diligent work involved in ensuring that their requests were clearly understood and that the participants in roundtables and other meetings had a full understanding of the issues facing the profession. HPRAC is also grateful for the participation of so many health professionals, associations and organizations in its consultations. The input and expertise of all involved was of great assistance to HPRAC in its work.

HPRAC is encouraged by the recognition of dietitians’ knowledge and expertise in numerous settings and expects that its recommendations will provide additional tools so they can be increasingly valuable participants in collaborative care models.

**Implementation Proposals**

To implement HPRAC’s recommendations, the following changes to legislation and regulations are proposed:

1. That the *Dietetics Act, 1991* be amended by adding a new section as follows:

   **Authorized Acts**

   3.1 In the course of engaging in the practice of dietetics, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to take blood samples by skin pricking\(^{33}\) for the purpose of monitoring capillary blood levels.

2. That the *Health Care Consent Act, 1996* be amended by repealing the definition of “evaluator” in section 2.1 and substituting the following:

   “evaluator” means, in the circumstances prescribed by the regulations, a person described in clause (a), (g), (l), (m), (o), (p) or (q) of the definition of “health practitioner” in this subsection or a member of a category of persons prescribed by the regulations as evaluators;

3. That Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by deleting the word “or” at the end of paragraph 9(1)(iv).

\(^{33}\) See Medical Laboratory Technology Act, Midwifery Act and Naturopathy Act for similar language.
4. That Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding the following paragraph:

(iv.1) at the request of a dietitian, in respect of a test specified in Appendix D,

5. That Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding Appendix D.

- HPRAC further recommends that the College of Dietitians of Ontario, with the advice of the College of Medical Laboratory Technologists of Ontario and the Ontario Association of Medical Laboratory Technologists, develop Appendix D, which would be subject to the approval of the Lieutenant-Governor in Council, with prior approval of the Minister.

6. That Ontario Regulation 683 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by deleting the semi-colon at the end of subparagraph 4(2)(b)(iv).

7. That paragraph 4(2)(b) of Ontario Regulation 683 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding the following:

(v) a dietitian,

8. That PART II – PERSONS PRESCRIBED TO ORDER TESTS of Ontario Regulation 207/94 under the *Medical Laboratory Technology Act, 1991* be amended by adding the following:

3. A member of the College of Dietitians of Ontario.
### Review of the Scope of Practice of Physiotherapy

#### Index

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPRAC’s Central Response</td>
<td>156</td>
</tr>
<tr>
<td>Background on Physiotherapy in Ontario</td>
<td>156</td>
</tr>
<tr>
<td>Physiotherapy’s Current Scope of Practice</td>
<td>157</td>
</tr>
<tr>
<td>What the College and the Association Have Proposed</td>
<td>157</td>
</tr>
<tr>
<td>Current Competency Requirements for Physiotherapists</td>
<td>159</td>
</tr>
<tr>
<td>How the College Regulates its Members</td>
<td>160</td>
</tr>
<tr>
<td>What HPRAC Learned from Research</td>
<td>162</td>
</tr>
<tr>
<td>Perspectives from the Consultations</td>
<td>163</td>
</tr>
<tr>
<td>An Enabling Regulatory Framework</td>
<td>166</td>
</tr>
<tr>
<td>HPRAC’s Observations</td>
<td>169</td>
</tr>
<tr>
<td>HPRAC’s Findings</td>
<td>170</td>
</tr>
<tr>
<td>Controlled Acts – Communicating a Diagnosis</td>
<td>172</td>
</tr>
<tr>
<td>Controlled Acts – Treating a Wound</td>
<td>173</td>
</tr>
<tr>
<td>Controlled Acts – Administering Oxygen or an Inhaled Drug or Substance</td>
<td>174</td>
</tr>
<tr>
<td>Controlled Acts – Instruments, Hands or Fingers</td>
<td>175</td>
</tr>
<tr>
<td>Controlled Acts – Ordering MRI and Diagnostic Ultrasound</td>
<td>177</td>
</tr>
<tr>
<td>Amendments to Other Legislation</td>
<td>178</td>
</tr>
<tr>
<td>Amendments to the Scope of Practice Statement</td>
<td>182</td>
</tr>
<tr>
<td>Conclusion</td>
<td>183</td>
</tr>
<tr>
<td>Implementation Proposals</td>
<td>184</td>
</tr>
</tbody>
</table>
Review of the Scope of Practice of Physiotherapy

The College of Physiotherapists of Ontario (the College) and the Ontario Physiotherapy Association (the Association) submitted a joint response to HPRAC’s scope of practice questionnaire. The submission was prepared in partnership with the academic community. HPRAC carefully considered this submission, as well as input from extensive research and consultation, in developing its recommendations.

HPRAC’s Central Response

Physiotherapists have the knowledge, skill and judgment to assume key roles in the delivery of primary health care and to address current and emerging health care needs of Ontarians. HPRAC’s research indicates that, with few exceptions, the educational preparation and entry to practice competencies of physiotherapists support the expansion of their professional scope of practice. Moreover, the College has appropriate safeguards in place to protect the public from harm. Where additional knowledge and training are needed, HPRAC is convinced that the College, the Association and the educational sector are committed to ensuring that physiotherapists meet the new requirements for safe, effective and professional care. Given the aging of the population and the rising incidence of chronic diseases affecting mobility and physical function, the expertise of physiotherapists will play an important role in responding to patients' needs.

Background on Physiotherapy in Ontario

Physiotherapists are university-educated primary health professionals who work in cardiorespiratory, orthopaedics, neurology, paediatrics, women's health, seniors' health, and sports, in a variety of settings, including hospitals, long-term care homes, home care, corporate enterprises and private practice. They work with other health professionals to deliver patient care within the physiotherapy scope of practice.

The College regulates the practice of physiotherapy in the public interest. To practice as a physiotherapist in Ontario, one must meet the entry to practice requirements set by the College and adhere to the standards of practice, code of ethics, guidelines, position statements and quality management programs developed by the College. There are five categories of registration: independent, academic, provisional, teaching and inactive.

In 2007/2008 there were 6,794 physiotherapists registered with the College, 6,390 of whom were in active, clinical practice. These levels represent an increase from 6,383 in 2006 and 5,972 in 2005.

There are five accredited undergraduate degree programs in physiotherapy in Ontario – at the University of Toronto, University of Western Ontario, McMaster University, University of Ottawa and Queen’s University.

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Chapter 5 – Review of the Scope of Practice of Physiotherapy

Physiotherapy’s Current Scope of Practice

In Ontario, the legislative framework for health professions includes an umbrella statute, the *Regulated Health Professions Act, 1991 (RHPA)*, and a series of profession-specific Acts. Among other provisions in the *RHPA* is a list of controlled acts, \(^3\) which are health care activities that carry a substantial risk of harm if performed by unqualified people.

Each profession-specific Act includes a scope of practice statement. The scope of practice statement in the *Physiotherapy Act, 1991* is:

> The practice of physiotherapy is the assessment of physical function and the treatment, rehabilitation and prevention of physical dysfunction, injury or pain, to develop, maintain, rehabilitate or augment function or to relieve pain. \(^4\)

The profession-specific Acts also indicate the controlled acts authorized to each profession. The *Physiotherapy Act, 1991* authorizes physiotherapists to perform the following controlled acts:

- moving the joints of the spine beyond a person’s normal physiological range of motion using a fast, low amplitude thrust, and
- tracheal suctioning.

The statute also provides for title protection, and use of the titles “physiotherapist” or “physical therapist” is restricted to College members. \(^5\)

Physiotherapists also perform additional controlled acts under medical directives or delegation, depending on their individual competence. These may include ordering tests, treating wounds, and oxygen titration. The College and the Association told HPRAC that most physiotherapists are working beyond the scope of practice that is defined in legislation, and have the education and training to do so. However, they are not currently allowed to perform this patient care on their own initiative, but must do so under delegation. Today, where they work, how they work with patients, the skills they bring to health care teams and their relationships with other health professionals are all very different from their role two decades ago. These realities create a pressing need for change to what physiotherapists are authorized to do.

What the College and the Association Have Proposed

The College and the Association have proposed changes to the scope of practice statement and authorized acts set out in the *Physiotherapy Act, 1991*, as well as amendments to other statutes and regulations.

1. *Scope of Practice Statement*

The proposed scope of practice statement reads:

> The practice of physiotherapy is the assessment of neuromuscular, musculoskeletal and cardiorespiratory systems to: (1) diagnose, treat and prevent disorders or diseases that

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\(^4\) Physiotherapy Act, 1991, s.3.

\(^5\) Physiotherapy Act, 1991, s. 8(1) and (2).
cause or are associated with physical dysfunction, injury and/or pain; ii) develop, maintain, rehabilitate or augment function; iii) relieve pain, and iv) promote mobility and health.

2. **Controlled Acts**

The proposed controlled acts are:

1. Communicating a diagnosis by identifying a physical dysfunction, disease or disorder as the cause of a person’s symptoms,
2. Treating a wound including by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound,
3. Administering by inhalation: i) oxygen, or ii) a drug or substance that has been ordered by a person who is authorized to do so by the [Chiropody Act, 1991](#), the [Dentistry Act, 1991](#), the [Medicine Act, 1991](#), the [Nursing Act, 1991](#), or the [Midwifery Act, 1991](#),
4. Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment or treatment, and
5. Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder: i) the application of electromagnetism for magnetic resonance imaging; and ii) the application of soundwaves for diagnostic ultrasound.

3. **Amendments to Related Legislation**

The proposed amendments to related legislation are:

- The [Healing Arts Radiation Protection Act](#) to allow physiotherapists to order x-rays,
- The [Laboratory and Specimen Collection Centre Licensing Act](#) to allow physiotherapists to order laboratory tests,
- The [Public Hospitals Act](#) to allow physiotherapists to initiate or order treatment or diagnostic procedures in a hospital, and
- The [Health Insurance Act](#) to allow physiotherapists to refer to appropriate specialists and to remove the requirement of a referral for physiotherapy services.

**For Future Consideration**

The College and the Association also raise future roles for physiotherapists in Ontario, including authorized acts to:

- Set or cast a fracture of a bone or dislocation of a joint,
- Apply or order the application of electricity for electromyography and nerve conductive studies, and
- Prescribe medication for the purposes of medication therapy management.

Ontario physiotherapists currently perform these activities under delegation, and physiotherapists are authorized to do so in other jurisdictions, including Britain and the United States. The analysis of how
the work of physiotherapists impacts patient outcomes is still being gathered. HPRAC has not examined these roles in its current review, but considers that they should be examined in the near future.

Rationale for the Proposal

According to the College and the Association, changes to the physiotherapy scope of practice are needed to accurately reflect care physiotherapists now competently provide to patients. Currently, they are providing some services through alternate authority mechanisms, after having demonstrated that they have the education and training at an entry to practice and post-graduate level to provide these services. The College and the Association agree that the legislative framework for physiotherapy does not adequately reflect the current roles that physiotherapists fulfill on a routine basis.

The College and the Association seek to:

- Expand and enhance interprofessional collaborative care by using physiotherapists’ competencies to the maximum,
- Align the scope of practice and controlled acts in the Physiotherapy Act, 1991 with present entry to practice and post-graduate education and with current practice roles,
- Increase efficiency in health care delivery by eliminating the need for alternate authority mechanisms such as medical directives and delegation where they are not warranted, and
- Reinforce professional accountability through increased regulatory rigour in standards and programs related to the authorized acts.

The College and the Association jointly emphasize that “the thrust of the proposed changes is aimed at enabling physiotherapists to function to their fullest individual competency, as stronger interprofessional, collaborative partners.”

Current Competency Requirements for Physiotherapists

The College sets the education, registration, quality improvement and continuing competence requirements for the practice of physiotherapy in Ontario.

Educational Preparation

Completion of a four-year bachelor’s degree from an accredited physiotherapy program is the minimum educational requirement for registration as a member of the College.

Ontario has five accredited university physiotherapy programs which are shaped by the Essential Competency Profile for Physiotherapists in Canada, the standards of the Accreditation Council for Canadian Physiotherapy Academic Programs, the Exam Blueprint for the national Physiotherapy Competency Examination, and curriculum guidelines from the Canadian Universities Physiotherapy Academic Council.

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9 University of Western Ontario, McMaster University, University of Toronto, Queen’s University and University of Ottawa.
10 National Physiotherapy Advisory Group. Essential Competency Profile for Physiotherapists in Canada. July 2004. (Note: the revised competencies have been approved and are expected to be published in 2008.)
The Canadian Alliance of Physiotherapy Regulators conducts a periodic analysis of physiotherapy practice in Canada, and uses its analysis to develop the Examination Blueprint for the Physiotherapy Competency Examination. The Accreditation Council for Canadian Physiotherapy Academic Programs requires that educational programs prepare students to meet expected standards for professional practice. The Canadian Universities Physiotherapy Academic Council publishes curriculum guidelines for entry to practice physiotherapy.\(^\text{1}\) The National Physiotherapy Advisory Group\(^\text{12}\) has recently endorsed the requirement of a professional master’s degree as a preferred entry-level qualification for Canadian physiotherapists, and anticipates that by 2010 all Canadian universities will offer physiotherapy programs only at the level of a professional master’s degree. This reflects trends in some international jurisdictions. Canadian regulators and physiotherapists have told HPRAC that there should be further discussion of this plan before it is implemented.

In addition to a university education, applicants to the College must pass the national Physiotherapy Competency Exam that includes a written and clinical component. The written component is a multiple-choice examination that evaluates understanding of the principles and processes of physiotherapy practice, including knowledge about essential physiotherapy skills, behaviours and abilities. Upon completion of the written component, candidates must complete the clinical component that uses an Observed Structured Clinical Examination format to evaluate knowledge and the safe and effective application of the principles and processes of physiotherapy practice.\(^\text{13}\)

**Internationally Educated Physiotherapists**

The number of internationally-educated physiotherapists is gradually increasing, from 16.6 percent of members in 2005/2006 to 17.6 percent in 2007/2008\(^\text{14}\). Internationally educated physiotherapists must have their credentials assessed by the Canadian Alliance of Physiotherapy Regulators to establish substantial equivalence with the accredited programs offered in Canada. Once equivalence is determined, the candidate may apply to write the Physiotherapy Competency Examination. Both written and clinical components must be successfully completed. If applicants are not found to have equivalent qualifications, they may be referred to a prior learning assessment and remediation process to identify gaps in knowledge and skill. It is anticipated that the number of international applicants for registration will continue to increase. A bridging program at Ryerson University has been funded by the Ontario and federal governments to help meet their needs. \(^\text{15}\)

**How the College Regulates its Members**

The College requires annual registration for physiotherapists that includes a declaration of the controlled acts that members are performing in the course of their practice. The College is currently developing assessment criteria for reports of post-graduate education and training for the performance of a controlled

\(^\text{12}\) The National Physiotherapy Advisory Group is comprised of the Accreditation Council for Canadian University Physiotherapy Academic Programs, the Canadian Alliance of Physiotherapy Regulators, the Canadian Physiotherapy Association and the Canadian Universities Physical Therapy Academic Council.
\(^\text{13}\) [www.alliancept.org/exams_overview.shtml](http://www.alliancept.org/exams_overview.shtml)
\(^\text{15}\) [http://ce-online.ryerson.ca/cce_2008-2009/program_sites/program_gateway.asp?id=2675](http://ce-online.ryerson.ca/cce_2008-2009/program_sites/program_gateway.asp?id=2675)
The College has developed comprehensive standards, guidelines and position statements to inform physiotherapists’ practice and ensure the continued provision of safe, quality care. The College’s Standard for Professional Practice: Controlled Acts outlines the requirements for physiotherapists to perform controlled acts, whether they are authorized to the profession or performed under delegation. The standard provides that physiotherapists may perform a controlled act, or any component of a controlled act, when they are acting within the physiotherapy scope of practice and when:

- The patient’s assessment results warrant the performance of the act,
- They are authorized to perform it,
- They are competent to perform it,
- They are able to manage the reasonably foreseeable outcomes related to the performance of the controlled act,
- They accept personal responsibility for the performance of the act, and
- They meet any other statutory, regulatory and professional responsibilities that apply.

The standard specifies that, in order to perform controlled acts, a physiotherapist must demonstrate competence and successful completion of further education where it is warranted. While the College does not currently assess or approve post-graduate education programs and courses, it requires that they include a didactic, clinical and evaluation component.

The standard also provides explicit performance expectations and measures to ensure physiotherapists are adhering to the standard in their practice. The accompanying Guide to the Standard for Professional Practice: Controlled Acts elaborates on the obligations of regulated physiotherapists with respect to performing controlled acts. It educates physiotherapists on the RHPA and controlled acts model so that they may understand their role in the broader system. The College’s professional misconduct regulation makes it an act of professional misconduct to fail to maintain the standards of practice of the profession. Amendments to the regulation to make it an act of professional misconduct to accept the delegation of a controlled act by another health professional unless the member has the knowledge, skill and judgment to perform the controlled act, are pending.

The submission also highlights the College’s well-established, best-practice informed, quality assurance program. Its purpose is to ensure that regulated physiotherapists continue to demonstrate competency beyond entry to practice. It consists of three components:

**Practice Reflection**: a continuous self-assessment process supported by College-developed tools to assist members in evaluating their practice.

**Practice Assessment**: Five percent of members are randomly selected annually for peer review to ascertain knowledge, skills and judgment.

**Practice Enhancement**: continuing education and training activities to address gaps in knowledge, skills and judgment identified during the practice assessment.

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16 College and Association submission, p. 21.
18 see [www.collegept.org](http://www.collegept.org)
19 College and Association submission, p.44.
What HPRAC Learned from Research

In addition to reviewing background information and the detailed submissions received from the College and the Association, HPRAC undertook a review of the published literature, a jurisdictional review of the scope of practice of physiotherapists outside Ontario, and a jurisprudence review of the scope of practice of physiotherapists nationally. The literature and jurisdictional reviews are posted on HPRAC’s website.

Literature Review

There is scant literature specifically on the issue of the scope of practice or enhanced scope of practice for physiotherapy. However, numerous studies and reports document the effectiveness of physiotherapy in the treatment of various conditions.

There is broad evidence to suggest that physiotherapy in primary health care models and in other health care delivery models (i.e., emergency triage, outpatient orthopaedic clinics) can have system, patient and provider impacts. Some studies have documented the impact and effectiveness of advanced roles for physiotherapists in general practice, rheumatology and respiratory clinics, triage and outpatient clinics, and emergency rooms. British studies have demonstrated cost effectiveness in the utilization of physiotherapists for managing musculoskeletal trauma in an emergency. These studies, in conjunction with anecdotal evidence, support the advancement of expanded roles for physiotherapists to respond to system needs and address barriers to access, including wait lists and physician shortages.

In Ontario, physiotherapists have been recognized as having the potential to play an important role in the effort to reduce wait times and improve patient outcomes in orthopaedics. The Expert Panel for Hip and Knee Replacement Surgery recommended to the Ontario Wait Times Strategy that physiotherapists and other alternate care providers could help tackle the wait list crisis in orthopaedics. British studies have demonstrated the impact and effectiveness of advanced roles for physiotherapists in general practice, orthopaedics, rheumatology and respirology.

While data on patient outcomes is lacking, early indications are that expanded practice physiotherapists can improve health care costs, patient satisfaction, timeliness of care and overall system productivity.

Jurisdictional Review

Ten Canadian and four international jurisdictions were examined. The definition of “physiotherapy” or “physical therapy” varies little across the jurisdictions studied. The profession is often described in such terms as, “removal, alleviation or prevention of movement, dysfunction or pain” using “clinical judgment and informed interpretation”. Some jurisdictions list common applications and modalities used to deliver care, such as:

- Assessment of neuromuscular, musculoskeletal and cardiorespiratory systems,
- Therapeutic exercise programs,
- Wound treatment,
- Joint manipulation, and
- Acupuncture.

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A minority of jurisdictions permit the invasive use of energy and the prescribing of topical medications. All jurisdictions reviewed include diagnosis, either in the scope of practice statement or in the description of the authorized practice of the profession.

All jurisdictions protect a number of titles for physiotherapists, such as “physiotherapist”, “physical therapist”, “registered physiotherapist” and “P.T.”.

Continuing competency requirements vary across jurisdictions. Quebec requires members to undertake an internship or improvement course if they return to practice after a hiatus of over three years. Britain obliges members to maintain a record of their continued proficiency, but no minimum requirements are set.

**Perspectives from the Consultations**

HPRAC’s consultation program was designed to gain additional information, perspectives and understanding of the issues, benefits and risks linked with changing the scope of practice for physiotherapists in Ontario. As part of the consultations, HPRAC held broad local health provider roundtables in five communities, met with other regulators and professional associations and conducted a number of key informant interviews. A separate meeting was also arranged with physiotherapy educators. In addition, at the beginning of the consultation process, a joint meeting was held with the College and the Association.

HPRAC received 26 written responses to the joint submission of the College and the Association and has considered them in its analysis and recommendations. All of the responses are available on HPRAC’s website.

The submission was a collaborative effort by the College, the Association and those responsible for physiotherapy education in the province. This tripartite group is known as the Ontario Physiotherapy Leadership Consortium. The Consortium reviewed data and evidence of current practice, education (entry to practice and post-graduate) and assessment. Experts, educators and practitioners were all involved.

The key points emerging from the roundtable consultations on the physiotherapy scope of practice referral are summarized under three main categories: System Needs, Scope of Practice and Competency.

**System Needs**

Participants in the roundtables said that the practice of physiotherapy has evolved significantly over the last 20 years. Whether in a hospital, family health team, community health centre, other community setting or in private practice, the nature of physiotherapist practice settings and responsibilities has changed. HPRAC learned of several pilot projects underway in a number of clinical settings. In these collaborative care models, the role of the physiotherapist is being developed to maximize the scope and competencies of the profession. Physiotherapists told HPRAC about a number of hospitals that are experimenting with a variety of collaborative care initiatives, such as joint assessment centres to provide better patient care. These initiatives involve maximizing the skills and talents of physiotherapists to help move the patient more quickly along the continuum of care. Many hospitals are also looking at how they can make better use of physiotherapists in emergency triage procedures to reduce wait times.
HPRAC heard from representatives of the Local Health Integration Networks, community care access centres (CCAC) and long-term care homes about the shortage of health professionals throughout the province, particularly in primary care. Access to appropriate care is a significant issue, particularly in the community. With the growth of chronic disease, the lack of family physicians is putting an added strain on the system. Participants said that increased access to physiotherapists could cut down on the number of referrals to emergency rooms and generally provide timely and effective patient care. There were numerous examples of ways in which physiotherapists could be more effectively used in community settings. The CCAC representatives see a role for physiotherapists, along with nurse practitioners, in assessing patients in long-term care homes and avoiding visits to hospital emergency departments.

Many physiotherapists said that a great deal of time is spent trying to get physician approval for a procedure they could do themselves.

**WHAT HPRAC HEARD ABOUT...SYSTEM NEEDS**

“Physiotherapists work very much in a team environment in acute care and a lot of times other team members such as nurses, pharmacists, dietitians and social workers recognize the benefit of having a physiotherapist assess the patient. If a broader range of team members could trigger a referral to the physiotherapist, access would be swifter.

In this day and age when the length of stay in the hospital is tremendously short, every hour can sometimes make a substantial difference. There are also cumulative effects over time, as a result of similar delays affecting many patients. It is truly an impediment when nursing staff have to get hold of the doctor to write an order before treatment can be initiated.”

Christine Edwards, Manager Physiotherapy Services, Windsor Regional Hospital Windsor, Ontario

“Regarding referrals to a specialist, we have to have the patient see the family doctor to seek the referral, and sometimes the need is very urgent. Rheumatoid arthritis can cause erosion and permanent damage to the joints within 16 weeks.”

Helen Johnson, Program Manager, Specialized Geriatric Services, Windsor Regional Hospital Windsor, Ontario

“I urge us to look at ways to work with the controlled acts model to incorporate collaborative care and interprofessional care because it is so critical. We have to ensure that the current legislative framework does not perpetuate the silos that exist. The legislation need not be seen as a barrier. The innovation that is going on in the community is amazing, and it’s frustrating to see regulators as a barrier to that innovation.”

Rocco Gerace, Registrar, College of Physicians and Surgeons of Ontario

“In treatment of the wound bed, the difficulty in coordinating a physiotherapist with a nurse for a home care visit is immense.”

Tricia Khan, Erie St. Clair CCAC
“In a long-term care or private practice setting, if a patient has a fall, we have to wait for a physician to order an x-ray or we must move the patient to a hospital and wait in the emergency room. The inability to diagnose or order imaging tests in those situations prevents us from carrying forward a referral or treatment plan. Without the diagnosis from a physician, we can't proceed. The patient who can be on a perfectly safe treatment plan must wait for treatment because we could not confirm whether a fracture existed or not until the physician was able to see the patient - often an eight to 12 hour wait in ER or a two to six week wait for the family physician, if they have one.”

Mike Poling, Physiotherapist
Thunder Bay, Ontario

Scope of Practice

There was agreement among the majority of participants that the proposed scope of practice statement reflects what physiotherapists do today. A number said that there might be other ways to word a revised statement, but the intent should remain the same.

It was noted by educators that what the College is requesting corresponds to what is permitted in other parts of Canada. In other provinces and territories, physiotherapists are authorized to communicate a diagnosis, do wound cleansing, administer oxygen by inhalation, and put a hand or finger beyond the labia majora. While other parts of the country have varied approaches for the ordering of MRIs and ultrasounds, a number of jurisdictions are now reviewing these issues. A number of anecdotal stories were presented showing how hospitals and family health teams are trying to better integrate physiotherapists into their respective care teams. All noted that greater use of physiotherapists dramatically improves the efficiency and coordination of patient care.

Participants also emphasized the need for better electronic health records and the need for increased interprofessional care as a means to ensure continuity and coordination of patient care.

WHAT HPRAC HEARD ABOUT...SCOPE OF PRACTICE

“In relation to the first proposed change, which is communicating a diagnosis, in all other Canadian jurisdictions, physiotherapists have the right within their scope. It is only in Ontario where that is not permitted within the scope.

The second one is related to wound cleansing, again in all other Canadian jurisdictions, physiotherapists are within scope to participate in wound cleansing and procedures that go beyond the dermis. Related to oxygen, again that is the same status. In all other Canadian jurisdictions, physiotherapists are permitted to do so. The same with the proposed change related to putting an instrument, a hand or a finger beyond the labia majora, physiotherapists across other Canadian jurisdictions, except for in B.C. where it is under delegation, is again within the scope of physiotherapists’ practice. The use of MRI and diagnostic ultrasound is a little bit more variable. I know for instance in B.C. they are looking at changes to the scope of practice that will be based upon this physiotherapy submission to HPRAC.”

Dawn Burnett, Director of Practice & Policy, Canadian Physiotherapy Association
Chapter 5 – Review of the Scope of Practice of Physiotherapy

Competency

HPRAC met with physiotherapy educators, who stressed that with a few minor adjustments, existing academic programs cover all of the procedures requested. Continuing education and a number of post-graduate courses or continuing education programs would ensure that the competency of physiotherapists is maintained.

Other colleges and associations whose members work closely with physiotherapists indicated broad agreement with the proposals put forth by the College and Association. In some cases, professions who currently perform some of the functions that physiotherapists are requesting be added to their scope, such as respiratory therapists, were also supportive of the expansion of physiotherapists’ roles. There were some questions about maintaining competency and the need for additional post-graduate training in some instances. Practising physiotherapists said that the College had historically played a strong role in ensuring the effective standards of practice for the profession and expressed confidence that it would continue to serve the public interest with its high standards.

WHAT HPRAC HEARD ABOUT…COMPETENCY

“With regard to oxygen administration, which in the document is referred to as an entry to practice competency, a valid point is made that there is already a duplication of efforts and that this is commonly delegated to physiotherapists in clinical practice. Certainly it would make a lot of sense for physiotherapists to be able to administer oxygen. We are very supportive, and we’re looking forward to working with the College and Association on the skill set and competence of our professions in the controlled acts.”

Carole Hamp, Professional Practice Advisor, College of Respiratory Therapists of Ontario

“The feedback from our profession, frankly, is very supportive. Although we have a few questions, we believe that the proposed model for expansion of the physiotherapy scope of practice is good. I think this support stems from the fact that we (occupational therapy) share a similar perspective in terms of being professions that have diverse roles across diverse sectors with a diverse client base, and I see that this model lends a terrific flexibility for systemic growth and evolution of practice.”

Christie Brenchley, Executive Director, Ontario Society of Occupational Therapists

An Enabling Regulatory Framework

While the RHPA was a momentous step forward in regulating health professions when it was passed in 1991 – so much so that other jurisdictions are still trying to emulate the model – it was designed to be living legislation. HPRAC contends that the regulatory framework must constantly change to meet the requirements of the 21st Century.

HPRAC is therefore proposing a new approach to the regulation of physiotherapy: an enabling regulatory framework. HPRAC’s approach builds on the principles of the RHPA. It recommends ways to make the regulatory framework more flexible and adaptable, while strengthening the accountability of the regulatory colleges and their members.
Chapter 5 – Review of the Scope of Practice of Physiotherapy

An enabling regulatory framework couples a broader scope of practice for a profession, contained in legislation and regulations, with appropriate standards, limitations and conditions to be established by the regulatory College for the performance of authorized acts. The standards of practice would be recognized in statute, giving the College the clear legal authority to mandate compliance by members. The College would be required to involve other professions in the development of these standards, nurturing interprofessional collaboration.

The proposed approach allows for the evolution of physiotherapy practice over time – consistent with “changes in practice environments, advances in technology and other emerging issues” – through standards, limitations and conditions adopted by the College without recourse to changes in legislation or regulation\textsuperscript{21}. This direction is balanced with an enhanced role for the College to more actively regulate the profession in the public interest and to ensure that an appropriate accountability framework is in place to protect the public from the risk of harm. Specifically, under the enabling model the College will have to address issues of continuing competence and the involvement of other professions in the development of standards, limitations and conditions. HPRAC concluded that the model provides a measured approach with the appropriate checks and balances to protect the public.

A fundamental difference between the proposed approach and the status quo is that the contemplated standards, limitations and conditions, with statutory force, are to be established by the College independent of the regulation-making process\textsuperscript{22}. Such a role for the College is consistent with its current and future objects under the \textit{RHPA}\textsuperscript{23}.

\textbf{Interprofessional Collaboration and the Development of Standards of Practice and Professional Practice Guidelines}

The Minister has requested HPRAC to:

recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession.

\textsuperscript{21} HPRAC has previously commented on the problems experienced by health regulatory colleges under the \textit{RHPA}, with the regulation-making process in Ontario. See: HPRAC, \textit{Regulation of Health Professions in Ontario: New Directions} (April 2006), pp.62-71.

\textsuperscript{22} See Health Professions Procedural Code, s.95, which provides:

“(1) Subject to the approval of the Lieutenant Governor in Council and with prior review of the Minister, the Council may make regulations,

(a) prescribing classes of certificates of registration and imposing terms, conditions and limitations on the certificates of registration of a class; …

(n) prescribing the standards of practice of the profession and prohibiting members from acting beyond the scope of practice of the profession in the course of practicing the profession; …

\textsuperscript{23} See: \textit{RHPA}, s.3(1) clauses 3, 4, 7 and 8. Forthcoming changes to the objects of the College, to take effect June 4, 2009, (or some other date established by proclamation) will re-cast these current objects as follows:

4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members. [Replacing the current clause 4.]

8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public. [New.]

9. To promote inter-professional collaboration with other health profession colleges. [New.]

10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues. [New.]
Chapter 5 – Review of the Scope of Practice of Physiotherapy

The Minister has also asked HPRAC to:

- take into account, when controlled acts are shared, of public expectations for high quality services no matter which health profession is responsible for delivering care or treatment.

Standards of Practice

The term “standards” or “standards of practice” is defined differently by various colleges and other professional entities. For the purposes of this report and specifically in respect of the scope of practice review, HPRAC refers to standards of practice as the rules, requirements, responsibilities and conditions that describe the College’s expectations for physiotherapy in Ontario to provide high quality, ethical and safe care to patients. At a minimum, a health profession’s standards of practice should include requirements concerning education, continuing competence, quality assurance, record-keeping, conflict of interest, mandatory discussion, consultation and transfer of care.

HPRAC’s recommended approach in respect of an expanded scope of practice is set out below:

In the Physiotherapy Act, 1991:

- provide authority for the performance of new authorized act(s),
- amend the scope of practice statement, if necessary, to address the parameters of the new authorized act(s),
- require members to perform all new authorized acts in accordance with any requirements prescribed in the regulations,
- provide for any other additional requirements for authorized acts that can be pre-determined and are non-exemptible,
- require members to identify the limits of their educational preparation and competencies, and to resolve situations beyond their expertise by consulting with or referring patients to other health professionals, and
- include a provision enabling Council to make regulations concerning requirements for the performance of new authorized act(s).

In the regulations made under the Physiotherapy Act, 1991:

- where appropriate, ensure that members provide satisfactory evidence of successful completion of a post-graduate program that meets approved criteria when they wish to engage in a new authorized act(s),
- require members to perform all new authorized acts in accordance with any standards of practice established by the College from time to time,
- provide for any clarification of authority for the performance of new authorized act(s) as necessary,
- require the College to develop standards of practice for the new authorized acts through a process of interprofessional collaboration with other colleges, individuals and entities, and
- require the College to post on its website the standards of practice and, in some cases, those members who are authorized to perform a new authorized act.
Interprofessional Development of Standards, Limitations and Conditions

A key element of HPRAC’s approach is the creation of a new Physiotherapy Standards Committee. This step would allow for full review and consultation on the matters to be included in standards, limitations and conditions, while providing flexibility to respond to the evolution of physiotherapy practice, as these matters would not have to be addressed in regulation.

The rationale for this proposal is to establish a permanent forum where legitimate concerns about the standards, limitations and conditions for physiotherapists’ performance of authorized acts can be meaningfully discussed and resolved among the health professions that will be engaged in collaborative practice with physiotherapists. Through these discussions best practices can also be established. The current legislative framework imposes no obligation upon the College to involve representatives of other relevant professions in the development of standards, limitations and conditions.

HPRAC acknowledges the inherent difficulty in legislating interprofessional collaboration between health professionals, but is convinced that the proposed model strikes a reasonable balance – requiring the College to develop standards, limitations and conditions with input from those with a range of relevant expertise, while at the same time not providing any one participant in the process with a power of veto. The self-regulatory role and responsibilities of the College are respected by placing responsibility for making appointments to the Physiotherapy Standards Committee with the College. HPRAC is further recommending that there be representation from the physiotherapy education community.

In following this approach, the standards of practice do not and would not include professional practice guidelines.

Professional Practice Guidelines

The regulatory colleges refer to professional practice guidelines in many ways. Some use this term, while others have employed the terms guidelines, clinical practice guidelines or other terms. Professional practice guidelines set out best practices for clinical care.

It is not within HPRAC’s mandate to develop professional practice guidelines. This falls within the mandate, the competence and the responsibility of the profession.

What HPRAC proposes to do, however, is to consider whether and what kind of an interprofessional process should be followed by the regulated health professions when they develop professional practice guidelines, particularly where one or more professions share the same or similar authorized act.

HPRAC will engage in consultation on and analysis of this issue as the second phase of HPRAC’s interprofessional collaboration project continues, with recommendations to the Minister to follow in 2009.

HPRAC’s Observations

The review of several scopes of practice has been undertaken in the context of HPRAC’s broader project on mechanisms to facilitate interprofessional collaboration. The purpose of reviewing the scope of practice of physiotherapists is to ensure that it reflects the evolution of the profession since the inception
of the *RHPA*, and that it is able to more effectively participate in providing collaborative care. The submission by the College and the Association described how the education, training and clinical practice of physiotherapists has changed in response to patient and system needs, health human resources challenges, and new technology. The College, too, has developed standards and guidelines to inform physiotherapists’ practice in the face of these changes.

The submission further highlights barriers to physiotherapists’ ability to practise to their maximum scope that are structural in nature. These, too, require attention, to enable the best use of the knowledge and skill of physiotherapists in all practice settings.

Physiotherapists work collaboratively with other health professionals to care for patients. They are key members of interprofessional teams that deal with specific patient populations (seniors, diabetics, surgical patients) or in certain settings (hospital emergency rooms, orthopaedic clinics). Enabling them to practice to their maximum competencies may mean extending their ability to initiate tests or procedures autonomously, but this should not be construed as incongruent with collaboration. In fact, utilizing the skills of each member of collaborative teams represents efficient and effective patient care, enhances the collaborative relationship and, in the end, improves patient care.

It is also true, however, that physiotherapists are primary care providers who are often a patient’s first and only point of contact with the health care system. This is particularly the case in the community setting and in rural and remote areas of the province. In these circumstances, allowing physiotherapists to maximize their competencies addresses the significant issues of access to and quality of care in areas and practice settings where health professionals are in short supply.

HPRAC recognizes the evolution of the educational preparation, skills and practice of physiotherapists. It also acknowledges that, in an era of increasing patient needs, health human resources shortages and the growing complexity of care required, it is important to fully utilize the expertise of all health professionals.

**HPRAC’s Findings**

The submission from the College and the Association, information from the literature and jurisdictional reviews, and responses to HPRAC’s consultation program have provided strong evidence for expanding the scope of practice of physiotherapy and authorizing additional controlled acts to the profession.

Whether by written submission or through participation in the roundtable discussions, stakeholders raised relatively little concern about the proposals put forward by the College and the Association. Rather, the evolution of the role of physiotherapists since the inception of the *RHPA*, together with the promise of further contributions by the profession, was widely recognized. It was frequently observed that physiotherapists have a key role to play in meeting the needs of an aging population and addressing a rising incidence of chronic diseases causing dysfunction and immobility.

The review of the scope of practice of physiotherapy has revealed that a fundamental change in regulatory approach is needed and can have a significant impact on the practice of physiotherapy. HPRAC heard from many physiotherapists and other professionals that the system of medical directives and delegation currently being utilized to enable physiotherapists to practice to the extent of their individual competencies is often inadequate, inflexible and unnecessary. Establishing alternate authority mechanisms to enable physiotherapists to provide appropriate patient care is often cumbersome and
undermines the notion of direct, professional accountability for the care of patients. Enhancing direct accountability for health professionals for acts performed within their professional scope and individual competence is preferable.

Therefore, the framework within which the following recommendations are made is an enabling one that will:

- Establish a broad professional scope of practice for physiotherapists under the Physiotherapy Act, 1991 and regulations,
- Place responsibility for setting appropriate and rigorous standards, limitations and conditions on practice, that could be changed over time, with the College, and
- Require interprofessional collaboration among professions in establishing standards of practice and professional practice guidelines.

HPRAC is confident in the ability of the College – in collaboration with other affected professions – to set the standards, limitations and conditions for the performance of controlled acts and to review and revise them as necessary in response to gaps in service, changing needs and further evolution of the profession. HPRAC is impressed by the level of collaboration on matters of self-regulation among the various physiotherapy partners – regulatory, professional and academic – to ensure the profession continues to meet public needs in a safe, ethical, effective and efficient manner. It is also impressed with the number of members of other professions who spoke positively about their working relationships with physiotherapists in collaborative care teams.

HPRAC recommends changes to the scope of practice of physiotherapy as outlined below. These proposals are consistent with the government’s initiatives to address current and emerging health care needs of Ontarians and provide more opportunity for collaborative care. HPRAC is of the view that physiotherapists are key players in primary health care, and that the recommended changes will enable them to contribute even more to the delivery of quality, seamless health care in Ontario.

**Scope of Practice Statement**

The scope of practice statement serves to provide the parameters within which regulated health professionals can exercise their authority to perform controlled acts. The scope of practice statement found in each profession-specific Act under the RHPA provides a frame of reference for the performance by regulated health professionals of their authorized acts. Regulated health professionals may perform their profession’s authorized acts only in the course of practising within the profession’s scope of practice.

In the context of the scope of practice reviews, a scope of practice statement would only be amended in the following situations:

When an act is added to the list of authorized acts conferred upon a health profession; and

When HPRAC is satisfied that its criteria for a scope of practice review have been met.

This analysis takes place when HPRAC considers the expansion of a health profession’s authorized acts. That is, HPRAC asks: will an expanded scope of practice statement encompass a new assessment, diagnostic, treatment or prevention opportunity for the profession that was previously prohibited? And: is this expansion necessary or desirable?

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24 Examples include HealthForceOntario, the Ontario Wait List Strategy and the emphasis on chronic disease management.
Chapter 5 – Review of the Scope of Practice of Physiotherapy

As HPRAC has stated in its document entitled the *Review of a Professional Scope of Practice under the RHPA*, a scope of practice includes many elements, one of which is the scope of practice statement. Based on the various elements that determine whether a scope of practice statement should be amended, HPRAC will provide the analysis and recommendations on the scope of practice statement after it has determined whether physiotherapists should be granted access to the additional controlled acts being proposed.

Only after consideration of all of the specific controlled acts being proposed by the College and the Association will it be clear how, and to what extent, the scope of practice statement needs to be amended.

**Controlled Acts – Communicating a Diagnosis**

In Ontario, the act of making a diagnosis is not a controlled act, but the communication of a diagnosis is. It is the act of communicating that diagnosis that poses a risk of harm because a patient must understand the diagnosis to consent to treatment, including invasive treatment. Currently, physiotherapists assess and establish a diagnosis but are unable to communicate a definitive physiotherapy diagnosis.

Concerns were raised by stakeholders as to what particular diseases physiotherapists might diagnose and communicate to patients. It is clear that physiotherapists can diagnose the causes of dysfunction, immobility, pain, and injury but diagnosing a disease caused uneasiness among some. Further discussions with the College and the Association indicated that some diseases are inextricably linked with dysfunction, such as arthritis or chronic obstructive pulmonary disease. In addition, it was suggested that the process of arriving at a physiotherapy diagnosis involves “ruling out” other conditions that would require medical intervention. In other words, diagnosis includes the diagnosis both of things that one can treat and things that are outside of one’s scope.

Since physiotherapists are primary care providers and may be a patient’s first, and only, point of contact with the health care system, HPRAC believes it is important to allow physiotherapists to communicate a diagnosis identifying a disease, dysfunction or disorder within the limits of the practice of physiotherapy and the individual competence of the member. HPRAC suggests the development of a standard of practice for the communication of a diagnosis, in collaboration with physicians and nurse practitioners through a Physiotherapy Standards Committee, and that the standard includes the requirement to refer to a physician or another health professional when a physiotherapist identifies a disease, the treatment for which is beyond the physiotherapy scope and for which medical or other intervention is required.

HPRAC will further discuss the activity of diagnosis in considering the profession’s request for amendments to the scope of practice statement later in this report.

**Recommendation:**

1. That physiotherapists be authorized to perform the controlled act of communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person’s symptoms.
Controlled Acts – Treating a Wound

Physiotherapists encounter wounds in their daily practice as they work with diabetics, post-surgical patients, burn victims and others. They apply adjunctive therapies such as electrical stimulation, ultrasound and ultraviolet light in the treatment of wounds. These therapies are recommended interventions in Canadian best practice guidelines on wound care. The Registered Nurses’ Association of Ontario Best Practice Guidelines for Skin and Wounds indicate the highest level of evidence supporting physical therapy interventions as effective in the treatment of the most common types of chronic wounds such as diabetic foot ulcers, pressure ulcers and chronic venous leg ulcers.  

However, physiotherapists are not authorized to perform any procedure below the dermis and currently must rely on other regulated health professionals to do the cleansing, soaking, irrigating, probing, debriding, packing or dressing of a wound. Those who have demonstrated competence through continuing education and training are successfully performing wound care under delegation or medical directives, most particularly in the hospital setting. A physiotherapist working in long-term care or home care faces significant challenges around receiving delegation to perform this controlled act. There are numerous opportunities for physiotherapists to obtain wound care competencies at the practice level, and there are also certification courses and two post-graduate programs that provide the necessary additional training.

The rationale for this request by the College and the Association speaks to system need and patient safety. When physiotherapists must rely on other health professionals to delegate or provide wound care, treatment may be delayed and the patient may be put at risk of serious infection. It is also inefficient to require a second health professional, most often a nurse, to attend to a patient when the physiotherapist could safely perform the wound care along with the physiotherapy intervention. In community settings, this inefficiency further exacerbates the strain on health human resources and delays the delivery of the best possible care.

Representatives of CCACs spoke of the difficulty in coordinating schedules of a nurse and a physiotherapist to be in a patient’s home at the same time when wound care is required along with mobility or other care, and indicated their enthusiastic support of this request.

Entry to practice competencies in physiotherapy include basic education on science, anatomy and physiology of dermis and mucous membranes, as well as pathological conditions that arise in wounds and burns, but there are limited opportunities for clinical practice. Assessment of skin integrity and wounds and the basis and application of therapeutic energy modalities are taught in entry to practice programs and form part of the national Physiotherapy Competency Examination.

There were concerns raised as to the extent of physiotherapists’ education and training relating to wound care. HPRAC agrees that the entry-to-practice curriculum does not fully prepare physiotherapists to perform acts below the dermis; however, HPRAC is convinced that their base education is acceptable, and that post-graduate education and training can readily be added. HPRAC understands that relatively
few physiotherapists currently report performing authorized acts below the dermis for the purpose of wound care. However, in the face of health human resources shortages in all settings, and particularly in long-term care and home care, it is recognized that utilizing the skills of appropriately-prepared physiotherapists would benefit patients.

Hence, HPRAC recommends that the authorized act should be granted to the profession, and to those physiotherapists who demonstrate evidence of post-graduate education and training in wound care. It is recommended that the Physiotherapy Standards Committee develop a standard of practice relating to wound care in collaboration with the nursing profession, and adhere to best practice guidelines such as those developed by RNAO and the Canadian Association of Wound Care. A new standard for this act would include requirements for reporting on the patient health record the action taken and the patient response.

Recommendation:

2. That physiotherapists be authorized to perform the controlled act of treating a wound by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.

Controlled Acts – Administering Oxygen or an Inhaled Drug or Substance

Physiotherapists currently have the authority to perform tracheal suctioning, part of the controlled act of inserting an instrument, hand or finger beyond the larynx. The act of administering oxygen is integral to tracheal suctioning because oxygen levels often decrease when tracheal suctioning is performed to clear secretions. Best practice around the management of ventilated patients suggests that patients should receive additional oxygenation prior to suctioning. In order to maintain optimum blood oxygen saturation levels, oxygen is required. In some cases, the administration of oxygen is delegated to the physiotherapist, but when that is not the case, either a nurse or respiratory therapist must be present to administer or adjust the oxygen. Similarly, patients who require inhaled drugs, such as Ventolin, because of respiratory conditions such as asthma, may require the administration of such drugs during suctioning or other physiotherapy intervention to increase mobility and ambulation.

The submission of the College and the Association clearly articulates that all physiotherapy curricula in Ontario include content on the administration of oxygen and the administration of inhaled drugs for cardiorespiratory conditions. There is sufficient education on the pharmacology and indications of drugs that affect respiratory status and for which timing of dosage is relevant to secretion clearance and exercise. The administration of oxygen and inhaled drugs is evaluated within physiotherapy programs and the national Physiotherapy Competency Examination tests knowledge and skill in the administration of oxygen, in particular.

The soon-to-be released updated content guidelines by the Canadian Universities Physiotherapy Academic Council will include the administration of oxygen and other inhaled drugs in entry to practice curricula. Specifically, “within the sections pertaining to cardiorespiratory systems, the guidelines will...

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30 Available online at [http://www.cawc.net](http://www.cawc.net)
31 Physiotherapy Act, 1991, s.4(2).
32 College and Association submission, Appendix A, p.8.
recommend inclusion of knowledge relating to therapeutic dosage, indications, contraindications and
genral effects of drugs on cardiorespiratory function, as well as skills in pulse oximetry and medication
delivery.”

The consultations and research undertaken revealed little concern, if any, with this request, other than that
it be clarified to be administration only and not initiation or prescription of oxygen or drugs. A
clarification was requested for the application of this act to mechanically ventilated patients. Both these
concerns were addressed by the College and the Association, who have indicated that authorization for
this act would be limited strictly to the administration of oxygen and inhaled drugs to non-mechanically
ventilated patients. The prescribing or ordering of the oxygen or other drug or substance would be done
by a health professional who is authorized to do so by his or her own professional scope, such as
physicians and nurse practitioners.

HPRAC is satisfied that this act can be authorized to the profession as an entry to practice competency,
however that it be undertaken strictly within the practice of physiotherapy interventions to maintain or
improve cardiopulmonary function.

Recommendation:

3. That physiotherapists be authorized to administer oxygen or an inhaled
drug or substance that has been ordered by a person authorized to do so.

Controlled Acts – Instruments, Hands or Fingers

Physiotherapists currently have the authority to perform spinal manipulation under the controlled act of
moving the joints of the spine beyond a person’s usual physiological range of motion using a fast, low
amplitude thrust. When that involves the lower part of the spine, or the coccyx, insertion of a finger
beyond the anal verge may be required. Chiropractors, who also perform spinal manipulation, have
access to the controlled act of putting a finger beyond the anal verge for this reason.

The main rationale for this request by the College is for the assessment and treatment of the pelvic floor
musculature, particularly in patients with issues of continence. The incidence of incontinence is
increasing, both in women and men. Incontinence is a condition that is associated with aging, chronic
diseases causing immobility, women’s health postpartum and men’s health post-prostatectomy.
Assessment of incontinence involves evaluation of the pelvic floor musculature. Emerging evidence
suggests that, “conservative management, particularly pelvic floor muscle training, has been shown to be
effective and is now recommended as a first-line treatment before consideration of surgery, based on low
risk, low-cost and demonstrated efficacy.” According to the International Continence Society, “the
mainstay of treatment for stress urinary incontinence is physiotherapy, with recourse to surgery where
indicated or desired.” It is preferable to avoid surgery where possible, given its possible complications,

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34 Physiotherapy Act, 1991; s.4(1).
35 Chiropractic Act, 1991; s.4(3).
36 Neumann, Patricia B. et al. “Physiotherapy for female stress urinary incontinence: a multicentre observational study”.
such as the risks of morbidity and mortality, voiding difficulty, failure of the procedure or future recurrence.\textsuperscript{38}

Relatively few physiotherapists in Ontario currently report performing this controlled act (approximately 64, according to the College). However, it is reasonable to expect that, as physicians and the public obtain more information about the effectiveness of physiotherapy interventions for the treatment of incontinence, coupled with demographic trends, the demand for such interventions will increase. The College has published a position statement for physiotherapists with advanced level training who engage in the treatment of urogenital and rectal conditions. It details the knowledge requirements for such physiotherapy interventions, as well as standards and guidelines to inform practice including issues of patient consent and infection control, among others.\textsuperscript{39}

According to the College and the Association, entry to practice education includes the theoretical basis for assessment and treatment as well as practical experience in the treatment modalities of biofeedback, electrical stimulation and pelvic floor exercises used to rehabilitate the pelvic floor. These are evaluated at the curriculum level, but opportunities for clinical evaluation are limited. Though the submission indicates that short post-graduate courses are available to teach the additional assessment and treatment skills, these are not well documented.

Currently all provinces, except British Columbia and Nova Scotia, allow physiotherapists to perform this act. Ontario physiotherapists currently performing such assessments and interventions do so under delegation. HPRAC is of the view that, given the invasiveness of the act and the risk of harm (sexual abuse, inappropriate touching), it is not appropriate that this act be delegated, particularly in situations where supervision by an authorized professional is inadequate.

Therefore, HPRAC recommends that the act be added to the scope of practice of physiotherapy and that only those who demonstrate evidence of post-graduate education and competencies be authorized to perform it. HPRAC recommends that further curriculum development is required to ensure physiotherapists obtain the appropriate education and training. It is further recommended that a standard of practice be developed by the Physiotherapy Standards Committee relating to the performance of this act, detailing the sensitivity required to perform an invasive procedure and requiring referral to an authorized professional where one’s competencies are insufficient.

Recommendation:

4. That physiotherapists be authorized to perform the controlled act of putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of manipulating the tailbone and for the purpose of assessing or rehabilitating pelvic musculature associated with urinary or fecal incontinence.

\textsuperscript{38} Ibid.
Chapter 5 – Review of the Scope of Practice of Physiotherapy

Controlled Acts – Ordering MRI and Diagnostic Ultrasound

The rationale for the request to authorize physiotherapists to order MRI and diagnostic ultrasound is to support physiotherapy assessment and diagnosis and to expedite access to care. Currently physiotherapists in advanced roles order diagnostic tests under medical directives, most often for the care of patients with musculoskeletal conditions. Access to diagnostic tests by physiotherapists varies depending on the institution or on the relationship of the physiotherapist with the physician or specialist. Many institutions, such as Sunnybrook Health Sciences Centre in Toronto, have integrated advanced level physiotherapy roles, under medical directives, with great success. However, in those cases where a patient presents directly to a physiotherapist with a problem that may require diagnostic imaging, the patient must be referred to a physician who can order the test. In a hospital without medical directives permitting physiotherapists to order diagnostic tests, time is spent obtaining orders rather than caring for patients.

Entry to practice education includes an introduction to MRI indications, contraindications and interpretation. Students are taught when use of these tests is appropriate and what information can be obtained from them in certain circumstances, such as musculoskeletal and neurotrauma. As for diagnostic ultrasound, again, students obtain theoretical knowledge of what information it provides, for example, when dealing with soft tissue conditions. Consultation with educators, however, clearly indicated the need for post-graduate training to obtain the competencies to order these tests appropriately, safely and judiciously. Post-graduate education, combining both theoretical and practical training, is available both in the university setting as well as through institutionally-based training programs. Physiotherapists working in advanced practice with post-operative orthopaedic patients use diagnostic ultrasound to investigate suspicion of deep vein thrombosis and those working with incontinent patients require transvaginal and transrectal ultrasound to inform their practice.

The literature indicates that with access to the right tools, physiotherapists can have significant impact on the system, on patient outcomes and on the productivity of other professionals. Studies highlighted in the literature review include analyses of diagnostic accuracy between physiotherapist and orthopaedic specialists and the appropriate use of MRI. There are also studies investigating the potential role of specially trained physiotherapists in hospital orthopaedic departments. One in particular noted that the use of physiotherapists in these roles is not only cost-effective but leads to greater patient satisfaction. The same study noted that physicians ordered more diagnostic tests and referred more patients for surgery than did physiotherapists.

British Columbia and New Brunswick authorize physiotherapists to order MRI and diagnostic ultrasound. It is anticipated that Alberta will introduce reforms to address access to diagnostic tests (a restricted activity) by physiotherapists as authorized by the College.

40 At the Holland Orthopaedic and Arthritic Centre campus.
42 College and Association submission, Appendix C.
Most concerns raised about this proposal in the consultation process related to wait lists for MRIs, patient records and possible duplication of tests. Respondents relayed concern that permitting physiotherapists to independently order MRI and ultrasound would further burden the system. HPRAC is of the view that any professionals authorized to order diagnostic tests must do so judiciously and according to patient need. Because of their knowledge of musculoskeletal, neuromuscular and cardiorespiratory systems, and their extensive assessment skills, physiotherapists may be able to quickly determine the cause of a person’s pain or dysfunction and proceed to conservative management before further complications arise, or refer the patient to another professional. In addition, whether a patient receives an MRI or ultrasound immediately on the order of a physiotherapist, or waits to see a physician for the ordering of that same test, the impact on the system is the same.

A common concern was the lack of a coordinating mechanism, such as an electronic health record, to reduce duplication and to ensure that full information is available to all involved in a patient’s care. Additionally, the need for improved communication between professionals and better coordination of care was frequently raised. The Ontario College of Family Physicians, for example, suggested, “collaborative team-based discussions between the [physiotherapist] and other health providers to ensure the appropriateness of ordering”. HPRAC recommends that physiotherapists with demonstrated evidence of appropriate post-graduate training be permitted to order MRI and diagnostic ultrasound for the purpose of informing a physiotherapy diagnosis. HPRAC further recommends that a Physiotherapy Standards Committee develop a standard of practice relating to this act, and that this be done in collaboration with physicians, nurse practitioners and medical radiation technologists. This standard should include the requirement to refer to and collaborate with physicians in those cases where medical intervention is indicated.

Recommendation:

5. a) That physiotherapists be authorized to perform the controlled act of ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder, i) the application of electromagnetism for magnetic resonance imaging, and ii) the application of sound waves for diagnostic ultrasound.

b) That regulations made under the Physiotherapy Act, 1991 should require the College to develop standards of practice for ordering the application of electromagnetism or sound waves through a process of interprofessional collaboration with other regulated health professions, individuals and entities.

Amendments to Other Legislation

Ordering X-rays

The profession is seeking authority to order x-rays as a diagnostic tool to support physiotherapy practice. Physiotherapists require access to different tests for different conditions and x-rays relate to assessment and treatment of bone structures. The College and the Association indicate that physiotherapists with post-graduate education and training are currently ordering x-rays in institutional settings under medical

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directives. Examples of patient populations include patients who have been referred for total hip or knee replacement who require evaluation and follow-up, or geriatric populations where falls are frequent and fractures are often suspected.

In the majority of Canadian jurisdictions, x-rays are ordered under medical directive. Entry-level education and training includes anatomy, the indications and contraindications of ordering x-rays and their interpretation. Post-graduate training is necessary for additional knowledge on the use of this modality. Both university and institution-based programs currently exist in Ontario.

HPRAC recommends that physiotherapists be added to the list of providers authorized to order x-rays under the legislation. HPRAC further recommends that the Physiotherapy Standards Committee develop standards of practice for the profession drawing on evidence-based best practices, including specific parts of the body for which physiotherapists can autonomously order x-rays in collaboration with physicians and medical radiation technologists. The standard should include protocols for the communication of results to the patient’s physician, as well as the requirement to refer to physicians when indications are beyond the profession’s scope and medical intervention may be required.

Recommendation:

6. a) That physiotherapists be authorized to order x-rays.
   b) That regulations made under the Physiotherapy Act, 1991 should require the College to develop standards of practice for ordering of x-rays through a process of interprofessional collaboration with other regulated health professions, individuals and entities.

Ordering Laboratory Tests

Access to some laboratory tests, such as blood tests, can facilitate assessment and diagnosis of certain conditions by physiotherapists. The College and the Association submission proposes a list of laboratory tests that physiotherapists could order. Currently in Ontario, physiotherapists with post-graduate education and training order laboratory tests under delegation, in particular in orthopaedic triage clinics where patients referred for total hip or knee replacement are evaluated and monitored post-surgery, and in rheumatology clinics where arthritis patients are evaluated and monitored. Physiotherapists working in wound care can also benefit from access to blood tests to assess possible infection or to determine if nutritional insufficiency is impeding healing – cases that would require referral to a physician or nurse practitioner. A dietitian may later address nutritional insufficiency.

Entry to practice education includes theory regarding indications and interpretation for some laboratory tests. It is evident that post-graduate education and training would be required to order and use laboratory tests appropriately. Some programs currently exist in Ontario.

HPRAC recommends that physiotherapists be permitted to order laboratory tests under the legislation, and that a list of tests pertinent to physiotherapists’ practice be developed in collaboration with the College of Medical Laboratory Technologists of Ontario and the Ontario Association of Medical Laboratory Technologists. HPRAC further recommends that the Physiotherapy Standards Committee

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47 College and Association Submission, Appendix B.
48 Ibid, Appendix C.
49 Ibid, Appendix C.
develop a standard for the ordering of diagnostic tests and that the standard includes the requirement to refer to a physician when indications are beyond the scope of the profession to treat.

**Recommendation:**

7. a) That physiotherapists be authorized to order laboratory tests.
   b) That regulations made under the *Physiotherapy Act, 1991* should require the College to develop standards of practice for ordering of laboratory tests through a process of interprofessional collaboration with other regulated health professions, individuals and entities.
   c) That the standards of practice should indicate the laboratory tests that physiotherapists should be authorized to order, the clinical purposes for the tests, the competencies required for the interpretation of the tests, and the protocols for referral to another health professional.

*Public Hospitals Act*

Throughout its review, HPRAC heard of numerous barriers to the ability of physiotherapists to practice to their maximum scope and competencies. In many cases, these barriers can be minimized by changes to the legislated scope of practice and controlled acts authorized to the profession. In others, however, the barriers are of a structural nature. These require amendments to complementary statutes or to facility and institutional protocols to enable physiotherapists' full participation as members of interprofessional care teams.

The submission by the College and Association highlighted the need for changes to the Hospital Management Regulation made under the *Public Hospitals Act* that would enable physiotherapists to initiate treatments and order diagnostic procedures without a medical directive. The *Public Hospitals Act*, and in particular, the medical directive model, has been cited by several professions as an impediment to their ability to practice to their full scope of practice in a hospital setting.

*Medical Directives*

Medical directives are physician instructions relating to the care and medical treatment of a specific patient population. They define the agreement of physicians regarding best practice for medical interventions and how other health professionals should be involved in carrying out treatment protocols. They contain the delegation and authority for identified health professionals to carry out treatment protocols when patients meet established criteria. They are written in accordance with evidence-based practice standards. These are not simple documents. Their development requires significant consultation and agreement among physicians and other professionals who provide patient services in hospitals and other health care settings. Because many of the procedures for which they are written are complex, they may take months or years to prepare. They are usually relevant to a particular practice setting and to specific professionals who work in that setting.

HPRAC has heard numerous comments and opinions about the effectiveness, development and implementation of medical directives, which have been cited as barriers to collaborative practice by many health professionals. Many say that medical directives impede collaboration because the interaction between professions occurs only when the directives are developed and there is no encouragement of
collaboration in actual patient care. Some feel shut out of the process when the directives are developed, and resent that others have determined their role. Some say that the protocols in medical directives are so difficult to develop and be approved that what was seen as state-of-the-art at the time quickly becomes out of date. Others say that medical directives provide direction for best practice and care.

The complex processes surrounding medical directives evolved as unintended consequences of the RHPA. Medical directives were intended to be a mechanism to promote team-based care through physician leadership and the delegation of authority to other professionals. Medical directives, by their nature, are hierarchical. The physician is accountable for the performance of the team. Professional silos, it was thought, would be reduced by recognizing the skills and knowledge of all team members, and by institutionalizing best practices in clinical care and in processes. Most often, authority of the physician would be transferred to other health professionals, some with greater expertise than the physician but without controlled act authorization, in order to provide appropriate patient care. HPRAC is firmly convinced that the benefits and challenges of medical directives and mechanisms to improve their development, implementation and evaluation should be further explored.

In its submission to HPRAC, the Ontario Hospital Association similarly acknowledged that,

> Until a comprehensive review of the [Public Hospitals Act] is undertaken, medical directives and delegation of controlled acts, as provided for in the RHPA, is useful to support the evolution of all regulated health professionals. Delegation, however, is not a permanent solution.50

Given HPRAC’s consideration of the education and competencies of physiotherapists, and the rationale outlined above, HPRAC recommends that the Hospital Management Regulation made under the Public Hospitals Act be amended to allow physiotherapists to order diagnostic tests that support their assessment and diagnosis of patients in hospital.

The submission also requested that physiotherapists be permitted to admit patients as outpatients, as this is currently being done under medical directives in some circumstances. HPRAC is of the view that there could be some value to allowing this activity, but that this is a matter that should be given greater consideration as part of a comprehensive review of the Public Hospitals Act.

**Recommendation:**

8. That as part of a comprehensive review of the Public Hospitals Act, amendments be made to the Hospital Management Regulation to permit physiotherapists to initiate or order treatment or diagnostic procedures in a hospital.

**Health Insurance Act**

The submission by the College and Association requested changes to the Health Insurance Act that relate to funding for physiotherapy services and funding for specialists to accept referrals directly from physiotherapists. In particular, the submission raised concerns about access to publicly-funded physiotherapy services, currently provided in designated physiotherapy clinics throughout the province.

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Chapter 5 – Review of the Scope of Practice of Physiotherapy

upon referral from a physician. The College and Association are seeking the removal of the requirement for a physician referral so that patients may self-refer to OHIP-funded physiotherapy clinics. The College and Association are requesting that specialists be permitted to accept referrals directly from physiotherapists.

HPRAC has refrained from making recommendations in this regard, except to note that issues of funding need to be considered in light of the recommendations HPRAC has made on the physiotherapy scope of practice.

Recommendation:

9. That no changes to the Health Insurance Act be made at this time.

Amendments to the Scope of Practice Statement

The College and the Association have requested that the scope of practice statement for physiotherapy be amended to explicitly mention the body systems that physiotherapists assess and treat and also to add the word “diagnose” to the description of the work done by physiotherapists.

The addition of the word “diagnose” would be a significant change to the scope of practice statement. In its previous report entitled Adjusting the Balance: A Review of the RHPA, HPRAC stated that, “a diagnosis involves the ability to identify a disease or disorder by drawing a conclusion based upon certain knowledge and skill.”

As submitted by the College and Association, and confirmed through HPRAC’s jurisdictional review, the majority of Canadian jurisdictions explicitly recognize the authority of physiotherapists to diagnose, though in most cases this is qualified as a “physiotherapy diagnosis”, “physical therapy diagnosis” or a “diagnostic assessment”. The international jurisdictions reviewed, with the exception of Queensland, Australia, also include reference to the diagnostic capabilities of physiotherapists.

The Essential Competency Profile for Physiotherapists in Canada (2004) was developed by the National Physiotherapy Advisory Group as a tool to inform curriculum development, continuing competency programs, registration practices and exam development, and as a resource to physiotherapists and non-physiotherapy stakeholders alike. Seven “dimensions” reflect the major functions for physiotherapists in fulfilling their role. Dimension Five: Physiotherapy Diagnosis/Clinical Impression and Intervention Planning clearly indicates that a physiotherapist, “establishes a physiotherapy diagnosis/clinical impression”. Performance measurements include how the physiotherapist determines the diagnosis on the basis of an analysis of client assessment findings, facilitates informed decision-making by clients, and establishes and prioritizes with the client a physiotherapy intervention. The profile document defines physiotherapy diagnosis/clinical impression as, “a conclusion about physical function based on a subjective and objective assessment and analysis by a physiotherapist to investigate the cause or the nature of a client’s condition or problem”.

52 Ibid: p.17.
Formulating a diagnosis based on a physiotherapy assessment is taught and tested at all physiotherapy programs and forms part of the national Physiotherapy Competency Exam. Discussions with physiotherapy educators confirmed this to be the case.

HPRAC concludes that making a diagnosis is in fact part of the work of physiotherapists. Clarity for both patients and other providers would be improved by referring to this role in the scope of practice statement.

HPRAC also considered the addition of the descriptors “neuromuscular”, “musculoskeletal” and “cardiorespiratory” in the scope of practice statement. This differs from the current scope of practice statement that states simply that physiotherapists assess “physical function”. HPRAC is of the view that scope of practice statements need only describe the broad practice of the profession, so as to provide the parameters within which controlled acts can be performed. HPRAC found it appropriate to include these particular descriptors to assist in determining the appropriate application of the controlled acts. The addition of these words also makes the boundaries of the work of physiotherapists clear to other professionals who work with them.

**Recommendation:**

10. That the scope of practice statement for physiotherapy read:

The practice of physiotherapy is the assessment of neuromuscular, musculoskeletal and cardiorespiratory systems, the diagnosis of diseases or disorders that are associated with physical dysfunction, injury or pain, and the treatment, rehabilitation and prevention of physical dysfunction, injury or pain to develop, maintain, rehabilitate or augment function, to relieve pain or to promote mobility.

**Conclusion**

HPRAC is grateful for the time and effort spent by the College and Association in preparing the submission and for their leadership in describing current physiotherapy practice throughout the consultation process. HPRAC is impressed by the profession’s commitment to regulation in the public interest, and by the enthusiasm of its members in providing team care. HPRAC has concluded that physiotherapists have the knowledge and training to assume additional roles within the health care system, and have demonstrated a mindset of continuous improvement that makes them willing to obtain additional qualifications so they can offer significant strength to patient care in collaborative practice.
Chapter 5 – Review of the Scope of Practice of Physiotherapy

Implementation Proposals

To implement HPRAC’s recommendations, the following changes to statutes and regulations are proposed:

1. That section 3 of the *Physiotherapy Act, 1991* be repealed and the following substituted:

   **Scope of practice**
   
   **3.** The practice of physiotherapy is the assessment of neuromuscular, musculoskeletal and cardiorespiratory systems, the diagnosis of diseases or disorders that cause or are associated with physical dysfunction, injury or pain, and the treatment, rehabilitation and prevention of physical dysfunction, injury or pain to develop, maintain, rehabilitate or augment function, relieve pain or promote mobility.

2. That section 4 of the *Physiotherapy Act, 1991* be repealed and the following substituted:

   **Authorized acts**
   
   **4.** In the course of engaging in the practice of physiotherapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

   1. Communicating a diagnosis identifying, as the cause of an individual’s symptoms, a disease, disorder or dysfunction that may be identified through a physiotherapy assessment.
   2. Treating a wound by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.
   3. Moving the joints of the spine beyond a person’s usual physiological range of motion using a fast, low amplitude thrust.
   4. Administering by inhalation oxygen, a drug or substance for the purpose of maintaining or improving cardiopulmonary function during physiotherapy interventions.
   5. Tracheal suctioning.
   6. Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of manipulating the tailbone and for the purpose of assessing or rehabilitating pelvic musculature associated with urinary or fecal incontinence.
   7. Ordering the application of a prescribed form of energy.

3. That the *Physiotherapy Act, 1991* be amended by adding the following sections:

   **Additional requirements for authorized acts**
   
   **4.1** A member shall perform a procedure under the authority of paragraph 1, 2, 4, 6 or 7 of section 4 in accordance with any requirements prescribed in the regulations.

   **4.2** A member shall not perform a procedure under the authority of paragraph 4 of section 4 unless the procedure is ordered, or the oxygen, drug or substance is prescribed, by a member of a College as defined in the *Regulated Health Professions Act, 1991* who has the authority to make the order or prescription.

   **Individual scope of practice for physiotherapists**
   
   **4.3** A member is responsible for identifying the limits of his or her educational preparation and competencies, and for resolving situations beyond his or her expertise by consulting with or referring patients to other health care professionals.
4. That the *Physiotherapy Act, 1991* be amended by adding the following section:

**Regulations**

11(b) Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council may make regulations:

(i) specifying requirements for the performance of procedures under the authority of paragraph 1, 2, 4, 6 or 7 of section 4; and

(ii) prescribing the forms of energy that a member may order for the purpose of paragraph 7 of section 4 of the Act and prescribing the purpose for which, or the circumstances in which, the form of energy may be ordered.

5. That Ontario Regulation 532/98 under the *Physiotherapy Act, 1991* be amended by adding the following:

6(6) It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of paragraph 1, 2, 6 or 7 of section 4 must: (a) provide satisfactory evidence of successful completion of a postgraduate program that meets approved criteria; and (b) ensure the procedure performed does not exceed the level of training completed.

(7) It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of paragraph 1, 2, 4, 6 or 7 of section 4 must ensure the procedure is performed in accordance with any standards of practice established by the College from time to time.\(^{55}\)

(8) For the purposes of paragraph 7 of section 4 of the Act, a member may order the application of electromagnetism for magnetic resonance imaging and the application of sound waves for diagnostic ultrasound.

6. That Ontario Regulation 532/98 under the *Physiotherapy Act, 1991* be amended by adding the following:

**PART IV
STANDARDS OF PRACTICE**

27. The College shall develop, establish and maintain standards of practice for those procedures performed under the authority of paragraph 1, 2, 4, 6 and 7 of section 4 of the Act.

28. The standards of practice referred to in section 27 shall be developed, established and maintained on the recommendation of the Physiotherapy Standards Committee.

29. For the purposes of section 28, the College shall establish the Physiotherapy Standards Committee referred to in section 28 and shall appoint the membership of the Physiotherapy Standards Committee, which shall include, at a minimum, one or more:

a) members of the Council;

b) members of the College (including practitioners and educators);

c) persons who are not and have not been members of the College or of the Council;

d) members of the College of Physicians and Surgeons of Ontario, approved by the College of Physicians and Surgeons of Ontario;
Chapter 5 – Review of the Scope of Practice of Physiotherapy

e) members of the College of Nurses of Ontario, approved by the College of Nurses of Ontario;
f) members of the College of Medical Laboratory Technologists of Ontario, approved by the College of Medical Laboratory Technologists of Ontario; and
g) members of the College of Medical Radiation Technologists of Ontario, approved by the College of Medical Radiation Technologists of Ontario.

30. The College shall post the following on its website:
   a) the standards of practice referred to in section 27; and
   b) a list of those members who are authorized to perform a procedure under the authority of paragraph 2 of section 4.

7. That Ontario Regulation 107/96 under the Regulated Health Professions Act, 1991 be amended by deleting the word “or” after paragraph 7.1(2)(b), by inserting the word “or” after paragraph 7.1(2)(c) and by adding a new paragraph (d) as follows:

       A member of the College of Physiotherapists of Ontario, with respect to ordering the application of sound waves for diagnostic ultrasound.

8. That subsection 6(1) the Healing Arts Radiation Protection Act be amended by adding the following paragraph (g), so that it reads:

       6(1) No person shall operate an X-ray machine for the irradiation of a human being unless the irradiation has been prescribed by, … (g) a member of the College of Physiotherapists of Ontario.

9. That paragraph 9(1)(a) of Ontario Regulation 682 under the Laboratory and Specimen Collection Centre Licensing Act be amended by adding the following:

       (iv.2) at the request of a physiotherapist, in respect of a test specified in Appendix E, …

10. That Ontario Regulation 682 under the Laboratory and Specimen Collection Centre Licensing Act be amended by adding Appendix E.

11. That paragraph 4(2)(b) of Ontario Regulation 683 under the Laboratory and Specimen Collection Centre Licensing Act be amended by adding the following:

       (vi) a physiotherapist,

12. That PART III – PERSONS PRESCRIBED TO ORDER TESTS of Ontario Regulation 207/94 under the Medical Laboratory Technology Act, 1991 be amended by adding the following:

       4. A member of the College of Physiotherapy of Ontario.
APPENDIX A – Summary of Recommendations

Summary of Recommendations: Pharmacy

1. That pharmacists be authorized to undertake medication therapy management.

2. That pharmacists be authorized to order laboratory tests for the purpose of medication monitoring and management.

3. That steps be taken towards the introduction of a minor ailments program in Ontario. To that end:
   - That the College and the Association, in collaboration with the Ontario Medical Association, the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the Registered Nurses' Association of Ontario, the Nurse Practitioners' Association of Ontario, other health professions, facilities, educators and Ministry representatives develop the details of a program that would be suitable in Ontario, including: the list of minor ailments that pharmacists could treat; an agreed formulary including Schedule I, II and III drugs; protocols for referral to and communication with other health professionals, obtaining patient consent, and record-keeping; options for reimbursement for professional services; and educational and competency requirements and quality assurance – among other matters. The working group should also outline an implementation plan, including any pilot projects that might be required, along with communications elements to advise patients of the program.
   - That the College incorporate practice standards for a minor ailments program in its regulatory regime, and that those standards be developed with the participation of other health professions.

4. That pharmacists be authorized to initiate therapy for smoking cessation, including prescribing Schedule I drugs.

5. That pharmacists not be authorized to independently initiate therapy for travel prophylaxis.

6. That pharmacists be authorized to administer drugs through injection and inhalation for the purpose of patient education and demonstration.

7. That pharmacists not be authorized to perform routine immunizations.

8. That pharmacists be authorized to perform a procedure on tissue below the dermis for the limited purpose of patient self-care education and chronic disease monitoring, including the use of lancing-type devices.
9. That pharmacists not be authorized to prescribe Schedule II and III drugs solely for the purposes of patient reimbursement under an insurance plan.

10. That the scope of practice statement for pharmacy be amended.

11. HPRAC recommends that the Health Care Consent Act, 1996 be amended to include pharmacists as “health care practitioners”.

12. That the Minister take steps to update the regulation to recognize all pharmacy students and interns at universities in Ontario.

Summary of Recommendations: Midwifery

1. That midwives be authorized to take blood samples from fathers and donors from veins or by skin pricking.

2. That the CMO develop standards, limitations and conditions in conjunction with other health professions to establish when and under what circumstances a midwife is authorized to undertake the controlled act of putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period.

3. That the Indications [Indications for Mandatory Discussion, Consultation and Transfer of Care] document be amended to specifically address how the use of a foetal scalp heart monitor must be treated in the context of consultation and referral.

4. That midwives be given the authority to put an instrument, hand or finger beyond the anal verge for the purpose of administering suppository medications.

5. That no changes are required to the Midwifery Act, 1991, or regulations made under that Act, to authorize midwives to assist at caesarian section births.

6. That the Midwifery Act, 1991 and regulations made under it should not be amended to clarify existing authorized acts.

7. That the Midwifery Act, 1991 should not be amended to authorize repair of routine perineal procedures and 3rd degree tears, to provide care related to 4th degree tears and intubation of newborns.

8. That the CMO should develop comprehensive standards of practice (limitations and conditions) for emergencies, that these standards should be incorporated into the CMO’s Indications document, and indicate the education and clinical training required to maintain competency for emergency procedures.

9. That midwives be granted access to order additional laboratory tests and diagnostics, consistent with their scope of practice.
10. That the regulations made under the *Midwifery Act, 1991* should require the College to develop standards of practice for the ordering of diagnostic tests through a process of interprofessional collaboration with other regulated health professions, individuals and entities.

11. That the standards of practice should indicate the diagnostic tests that midwives should be authorized to order, the clinical purpose for the tests, the competencies required for the interpretation of the tests, and the protocols for referral to a specialist.

12. That midwives not be authorized to order maternal postpartum ultrasounds and newborn follow-up ultrasounds.

13. That no change to the *Ambulance Act* be made.

14. That midwives be authorized to communicate a diagnosis of a disease, disorder or dysfunction that may be identified through a midwifery assessment.

15. That no changes be made to the scope of practice statement in the *Midwifery Act, 1991*.

16. That an extended class registration category for members of the College of Midwifery not proceed.

**Summary of Recommendations: Dietetics**

1. That no change is required to the *Dietetics Act, 1991* concerning the controlled act of communicating a diagnosis.

2. That an early dialogue take place between the College of Dietitians of Ontario and the College of Physicians and Surgeons of Ontario to establish, for both professions, guidelines on referral and reporting practices to and from the professions, and that those be communicated to members of both professions.

3. That registered dietitians be authorized to take blood samples by skin pricking for the purpose of monitoring capillary blood levels.

4. That dietitians not be authorized the controlled act of prescribing or dispensing specifically for the adjustment of insulin or oral hypoglycemic regimens.

5. That dietitians not be authorized to perform the controlled act of psychotherapy.

6. That the creation of two new controlled acts for the prescription and management of enteral and parenteral nutrition and the prescription and management of therapeutic diets is not required.

7. That no change be made to the scope of practice statement for dietitians.
Appendix A – Summary of Recommendations

8. That section 24 of the Hospital Management Regulation made under the *Public Hospitals Act* be amended to authorize dietitians to order specified laboratory tests relative to nutritional assessment and monitoring.

9. That Regulation 682 and Regulation 683 made under the *Laboratory and Specimen Collection Centre Licensing Act, 1991* be amended to allow dietitians to order specified laboratory tests relevant to nutritional assessment and monitoring outside the hospital setting.

10. That the College work with the College of Medical Laboratory Technologists of Ontario, the College of Physicians and Surgeons of Ontario and others, as required, to develop a list of appropriate laboratory tests related to nutritional assessment that could be ordered by dietitians.

11. That dietitians be added to the list of health professionals authorized as evaluators under the *Health Care Consent Act, 1996*.

**Summary of Recommendations: Physiotherapy**

1. That physiotherapists be authorized to perform the controlled act of communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person’s symptoms.

2. That physiotherapists be authorized to perform the controlled act of treating a wound by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.

3. That physiotherapists be authorized to administer oxygen or an inhaled drug or substance that has been ordered by a person authorized to do so.

4. That physiotherapists be authorized to perform the controlled act of putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of manipulating the tailbone and for the purpose of assessing or rehabilitating pelvic musculature associated with urinary or fecal incontinence.

5. a) That physiotherapists be authorized to perform the controlled act of ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder, i) the application of electromagnetism for magnetic resonance imaging, and ii) the application of sound waves for diagnostic ultrasound.
   b) That regulations made under the *Physiotherapy Act, 1991* should require the College to develop standards of practice for ordering the application of electromagnetism or sound waves through a process of interprofessional collaboration with other regulated health professions, individuals and entities.

6. a) That physiotherapists be authorized to order x-rays.
   b) That regulations made under the *Physiotherapy Act, 1991* should require the College to develop standards of practice for ordering of x-rays through a process of
interprofessional collaboration with other regulated health professions, individuals and entities.

7.  a) That physiotherapists be authorized to order laboratory tests.
    b) That regulations made under the Physiotherapy Act, 1991 should require the College to develop standards of practice for ordering of laboratory tests through a process of interprofessional collaboration with other regulated health professions, individuals and entities.
    c) That the standards of practice should indicate the laboratory tests that physiotherapists should be authorized to order, the clinical purposes for the tests, the competencies required for the interpretation of the tests, and the protocols for referral to another health professional.

8. That as part of a comprehensive review of the Public Hospitals Act, amendments be made to the Hospital Management Regulation to permit physiotherapists to initiate or order treatment or diagnostic procedures in a hospital.

9. That no changes to the Health Insurance Act be made at this time.

10. That the scope of practice statement for physiotherapy read:

    The practice of physiotherapy is the assessment of neuromuscular, musculoskeletal and cardiorespiratory systems, the diagnosis of diseases or disorders that are associated with physical dysfunction, injury or pain, and the treatment, rehabilitation and prevention of physical dysfunction, injury or pain to develop, maintain, rehabilitate or augment function, to relieve pain or to promote mobility.
APPENDIX B – Summary of Implementation Recommendations

Summary of Implementation Recommendations: Pharmacy

To implement HPRAC’s recommendations, the following changes to statutes and regulations are proposed:

1. That section 3 of the *Pharmacy Act, 1991* be repealed and the following substituted:

   **Scope of practice**

   3. The practice of pharmacy is the promotion of health and the prevention and treatment of diseases, disorders and dysfunction through the monitoring and management of medication therapy; the custody, prescribing, compounding and dispensing of drugs; and the provision of health care aids and devices and education related to their use.

2. That section 4 of the *Pharmacy Act, 1991* be repealed and the following substituted:

   **Authorized acts**

   4. In the course of engaging in the practice of pharmacy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

   1. Dispensing, selling or compounding a drug or supervising the part of a pharmacy where drugs are kept.
   2. Skin pricking for the purpose of educating patients on the use of health care aids and devices and for the purpose of monitoring chronic diseases.
   3. Administering, by injection or inhalation, a substance for the purpose of patient education or demonstration.
   4. Prescribing drugs as prescribed in the regulations.

3. That the *Pharmacy Act, 1991* be amended by adding the following sections:

   **Additional requirements for authorized acts**

   4.1. A member shall perform a procedure under the authority of paragraphs 2, 3 or 4 of section 4 in accordance with any requirements prescribed in the regulations.

   4.2. A member shall not perform a procedure under the authority of paragraph 3 of section 4 unless the substance is prescribed by a member of a College as defined in the *Regulated Health Professions Act, 1991* who has the authority to make the prescription.

   **Individual scope of practice for pharmacists**

   4.3. A member is responsible for identifying the limits of his or her educational preparation and competencies, and for resolving situations beyond his or her expertise by consulting with or referring patients to other health care professionals.
4. That the *Pharmacy Act, 1991* be amended by adding the following section:

**Regulations**

14.(1) Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council may make regulations,

(a) designating the drugs that may be prescribed by members in the course of engaging in the practice of pharmacy;

(b) designating the circumstances in which a member may prescribe drugs in the course of engaging in the practice of pharmacy; and

(c) specifying requirements for the performance of procedures under the authority of paragraphs 2, 3 or 4 of section 4.

**Individual drugs or categories**

14.(2) A regulation made under paragraph 14(1)(a) may designate or specify individual drugs or categories of drugs.

5. That section 1.5 of Ontario Regulation 681/93 under the *Pharmacy Act, 1991* (Professional Misconduct) be repealed and the following substituted:

1.5. Prescribing, dispensing or selling drugs for an improper purpose.

6. That section 22 of Ontario Regulation 681/93 under the *Pharmacy Act, 1991* (Professional Misconduct) be repealed and the following substituted:

22. Contravening, while engaged in the practice of pharmacy, any federal or provincial law or municipal by-law with respect to the distribution, sale, prescribing or dispensing of any drug or mixture of drugs.

7. That section 28 of PART IV (General) of Ontario Regulation 202/94 under the *Pharmacy Act, 1991* be amended by adding the following:

(4) It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of paragraphs 3 or 4 of section 4 of the Act must: (a) provide satisfactory evidence of successful completion of a program that meets approved criteria; and (b) ensure the procedure performed does not exceed the level of training completed.

(5) It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of paragraphs 2, 3 or 4 of section 4 of the Act must ensure the procedure is performed in accordance with any standards of practice established by the College from time to time.

(6) A holder may only prescribe drugs under the authority of paragraph 4 of section 4 of the Act for the purposes of medication therapy management, treating minor ailments, smoking cessation therapy or as otherwise prescribed in the regulations.

(7) For the purposes of section 28(6), “medication therapy management” means professional activities and responsibilities of the member designed to optimize therapeutic outcomes for a patient according to the needs of the
individuals being treated as set out in detail in the standards of practice developed by the College;

“minor ailments” means a designated list of conditions for which a member is authorized to prescribe designated drugs as set out in regulation and in the standards of practice developed by the College; and

“smoking cessation therapy” means professional activities and responsibilities of the member designed to assess, initiate and monitor the most appropriate therapy for smoking cessation, including the prescribing of designated drugs as set out in regulation and in the standards of practice developed by the College.

8. That Ontario Regulation 202/94 under the *Pharmacy Act, 1991* be amended by adding the following:

PART IX

STANDARDS OF PRACTICE

52. The College shall develop, establish and maintain standards of practice for those procedures performed under the authority of paragraphs 2, 3 and 4 of section 4 of the Act.

53. The standards of practice referred to in section 52 shall be developed on the recommendation of the Pharmacy Standards Committee.

54. For the purposes of section 53, the College shall establish the Pharmacy Standards Committee referred to in section 53 and shall appoint the membership of the Pharmacy Standards Committee, which shall include, at a minimum, one or more:

a) members of the Council;

b) members of the College (including practitioners and educators);

c) persons who are not and have not been members of the College or of the Council;

d) members of the College of Physicians and Surgeons of Ontario, approved by the College of Physicians and Surgeons of Ontario, who practice family medicine;

e) members of the College of Nurses of Ontario, approved by the College of Nurses of Ontario; and

f) members of the College of Medical Laboratory Technologists of Ontario, approved by the College of Medical Laboratory Technologists of Ontario.

55. The College shall post the following on its website:

a) the standards of practice referred to in section 52; and

b) a list of those members who are authorized to perform a procedure under the authority of paragraphs 2, 3 and 4 of section 4 of the Act.

9. That paragraph 9(1)(a) of Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding the following:

(iv.3) at the request of a pharmacist, in respect of a test specified in Appendix F.

10. That Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding Appendix F.

11. That paragraph 4(2)(b) of Ontario Regulation 683 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding the following:
Appendix B – Summary of Implementation Recommendations

(iv.3) a pharmacist,

12. That PART III – PERSONS PRESCRIBED TO ORDER TESTS of Ontario Regulation 207/94 under the Medical Laboratory Technology Act, 1991 be amended by adding the following:

5. A member of the Ontario College of Pharmacists.

13. That section 2(1) of the Health Care Consent Act, 1996 be amended by adding the following:

(s.1) a member of the Ontario College of Pharmacists,

14. That the Minister of Health and Long-Term Care, in consultation with the Ontario College of Pharmacists, amend sections 30, 31 and 32 of PART IV Ontario Regulation 202/94 under the Pharmacy Act, 1991 to recognize University of Waterloo students and interns in addition to those from University of Toronto.

Summary of Implementation Recommendations: Midwifery

To implement HPRAC’s recommendations, the following changes to statutes and regulations are proposed:

1. That section 4 of the Midwifery Act, 1991 be repealed and the following substituted:

   Authorized acts

   4. In the course of engaging in the practice of midwifery, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

   1. Communicating a diagnosis of a disease, disorder or dysfunction that may be identified through a midwifery assessment.
   2. Managing labour and conducting spontaneous normal vaginal deliveries.
   3. Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area.
   4. Administering, by injection or inhalation, a substance designated in the regulations.
   5. Putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period.
   6. Putting an instrument, hand or finger beyond the anal verge for the purpose of administering suppository drugs designated in the regulations.
   7. Taking blood samples from newborns by skin pricking or from women, fathers or sperm donors from veins or by skin pricking.
   8. Inserting urinary catheters into women.
   9. Prescribing drugs designated in the regulations.
2. That the *Midwifery Act, 1991* be amended by adding the following sections:

**Additional requirements for authorized acts**

4.1 A member shall perform a procedure under the authority of section 4 in accordance with any requirements prescribed in the regulations.

**Individual scope of practice for midwives**

4.3 A member is responsible for identifying the limits of his or her educational preparation and competencies, and for resolving situations beyond his or her expertise by consulting with or referring patients to other health care professionals.

3. That section 11 of the *Midwifery Act, 1991* be repealed and the following substituted:

**Regulations**

11. (1) Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council may make regulations,
   (a) designating the substances that may be administered by injection or inhalation by members in the course of engaging in the practice of midwifery;
   (b) designating the drugs that may be prescribed by members in the course of engaging in the practice of midwifery;
   (c) specifying the drugs that a member may use in the course of engaging in the practice of midwifery;
   (d) specifying requirements for the performance of procedures under the authority of section 4.

4. That Ontario Regulation 867/93 under the *Midwifery Act, 1991* be amended by adding the following:

3.1 It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of section 4 of the Act must ensure the procedure is performed in accordance with any standards of practice established by the College from time to time.

3.2 It is a term, condition and limitation of a certificate of registration of any class that the holder must comply with the standards, limitations and conditions set out in the publication of the College entitled “Indications for Mandatory Discussion, Consultation and Transfer of Care Guideline”, as that publication is amended by the College from time to time.

5. That section 5 of Ontario Regulation 867/93 under the *Midwifery Act, 1991* be deleted.

6. That Ontario Regulation 867/93 under the *Midwifery Act, 1991* be amended by adding the following:

**STANDARDS OF PRACTICE**

10.1 The College shall develop, establish and maintain standards of practice for those procedures performed under the authority of section 4 of the Act that are referred to in section 3.1.
Appendix B – Summary of Implementation Recommendations

10.2 The College shall develop, and if required amend from time to time, the publication entitled “Indications for Mandatory Discussion, Consultation and Transfer of Care Guideline” referred to in section 3.2.

10.3 The standards of practice referred to in section 3.1 and the publication referred to in section 3.2 shall be developed on the recommendation of the Midwifery Standards Committee.

10.4 For the purposes of section 10.3, the College shall establish the Midwifery Standards Committee referred to in section 10.3 and shall appoint the membership of the Midwifery Standards Committee, which shall include, at a minimum, one or more:

a) members of the Council;
b) members of the College (including practitioners and educators);
c) persons who are not and have not been members of the College or of the Council;
d) members of the College of Physicians and Surgeons of Ontario, approved by the College of Physicians and Surgeons of Ontario, who practice obstetrics, gynecology or family medicine;
e) members of the College of Nurses of Ontario, approved by the College of Nurses of Ontario; and
f) members of the College of Medical Laboratory Technologists of Ontario, approved by the College of Medical Laboratory Technologists of Ontario.

10.5 The College shall post the standards of practice referred to in section 3.1 and the publication referred to in section 3.2 on its website.

7. That Appendix B of Ontario Regulation 682 under the Laboratory and Specimen Collection Centre Licensing Act be amended by adding the tests determined by the College on the recommendation of the Midwifery Standards Committee.

Summary of Implementation Recommendations: Dietetics

To implement HPRAC’s recommendations, the following changes to legislation and regulations are proposed:

1. That the Dietetics Act, 1991 be amended by adding a new section as follows:

   Authorized Acts

   3.1 In the course of engaging in the practice of dietetics, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to take blood samples by skin pricking for the purpose of monitoring capillary blood levels.

2. That the Health Care Consent Act, 1996 be amended by repealing the definition of “evaluator” in section 2.1 and substituting the following:

   “evaluator” means, in the circumstances prescribed by the regulations, a person described in clause (a), (g), (l), (m), (o), (p) or (q) of the definition of “health practitioner” in this

388 See Medical Laboratory Technology Act, Midwifery Act and Naturopathy Act for similar language.

Interprofessional Collaboration Phase II

September 2008
subsection or a member of a category of persons prescribed by the regulations as evaluators;

3. That Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by deleting the word “or” at the end of paragraph 9(1)(iv).

4. That Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding the following paragraph:

   (iv.1) at the request of a dietitian, in respect of a test specified in Appendix D,

5. That Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding Appendix D.

   - HPRAC further recommends that the College of Dietitians of Ontario, with the advice of the College of Medical Laboratory Technologists of Ontario and the Ontario Association of Medical Laboratory Technologists, develop Appendix D, which would be subject to the approval of the Lieutenant-Governor in Council, with prior approval of the Minister.

6. That Ontario Regulation 683 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by deleting the semi-colon at the end of subparagraph 4(2)(b)(iv).

7. That paragraph 4(2)(b) of Ontario Regulation 683 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding the following:

   (v) a dietitian,

8. That PART II – PERSONS PRESCRIBED TO ORDER TESTS of Ontario Regulation 207/94 under the *Medical Laboratory Technology Act, 1991* be amended by adding the following:

   3. A member of the College of Dietitians of Ontario.

**Summary of Implementation Recommendations: Physiotherapy**

To implement HPRAC’s recommendations, the following changes to statutes and regulations are proposed:

1. That section 3 of the *Physiotherapy Act, 1991* be repealed and the following substituted:

   **Scope of practice**

   3. The practice of physiotherapy is the assessment of neuromuscular, musculoskeletal and cardiorespiratory systems, the diagnosis of diseases or disorders that cause or are associated with physical dysfunction, injury or pain, and the treatment, rehabilitation and prevention of physical dysfunction, injury or pain to develop, maintain, rehabilitate or augment function, relieve pain or promote mobility.
2. That section 4 of the *Physiotherapy Act, 1991* be repealed and the following substituted:

**Authorized acts**

4. In the course of engaging in the practice of physiotherapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

   1. Communicating a diagnosis identifying, as the cause of an individual’s symptoms, a disease, disorder or dysfunction that may be identified through a physiotherapy assessment.
   2. Treating a wound by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.
   3. Moving the joints of the spine beyond a person’s usual physiological range of motion using a fast, low amplitude thrust.
   4. Administering by inhalation oxygen, a drug or substance for the purpose of maintaining or improving cardiopulmonary function during physiotherapy interventions.
   5. Tracheal suctioning.
   6. Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of manipulating the tailbone and for the purpose of assessing or rehabilitating pelvic musculature associated with urinary or fecal incontinence.
   7. Ordering the application of a prescribed form of energy.

3. That the *Physiotherapy Act, 1991* be amended by adding the following sections:

   **Additional requirements for authorized acts**

   4.1 A member shall perform a procedure under the authority of paragraph 1, 2, 4, 6 or 7 of section 4 in accordance with any requirements prescribed in the regulations.
   4.2 A member shall not perform a procedure under the authority of paragraph 4 of section 4 unless the procedure is ordered, or the oxygen, drug or substance is prescribed, by a member of a College as defined in the *Regulated Health Professions Act, 1991* who has the authority to make the order or prescription.

   **Individual scope of practice for physiotherapists**

   4.3 A member is responsible for identifying the limits of his or her educational preparation and competencies, and for resolving situations beyond his or her expertise by consulting with or referring patients to other health care professionals.

4. That the *Physiotherapy Act, 1991* be amended by adding the following section:

**Regulations**

11(b) Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council may make regulations:

   (i) specifying requirements for the performance of procedures under the authority of paragraph 1, 2, 4, 6 or 7 of section 4; and
   (ii) prescribing the forms of energy that a member may order for the purpose of paragraph 7 of section 4 of the Act and prescribing the purpose for which, or the circumstances in which, the form of energy may be ordered.

5. That Ontario Regulation 532/98 under the *Physiotherapy Act, 1991* be amended by adding the following:
Appendix B – Summary of Implementation Recommendations

6(6) It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of paragraph 1, 2, 6 or 7 of section 4 must: (a) provide satisfactory evidence of successful completion of a postgraduate program that meets approved criteria; and (b) ensure the procedure performed does not exceed the level of training completed.

(7) It is a term, condition and limitation of a certificate of registration of any class that the holder who performs a procedure under the authority of paragraph 1, 2, 4, 6 or 7 of section 4 must ensure the procedure is performed in accordance with any standards of practice established by the College from time to time. 389

(8) For the purposes of paragraph 7 of section 4 of the Act, a member may order the application of electromagnetism for magnetic resonance imaging and the application of sound waves for diagnostic ultrasound.

6. That Ontario Regulation 532/98 under the Physiotherapy Act, 1991 be amended by adding the following:

PART IV
STANDARDS OF PRACTICE

27. The College shall develop, establish and maintain standards of practice for those procedures performed under the authority of paragraph 1, 2, 4, 6 and 7 of section 4 of the Act.

28. The standards of practice referred to in section 27 shall be developed, established and maintained on the recommendation of the Physiotherapy Standards Committee.

29. For the purposes of section 28, the College shall establish the Physiotherapy Standards Committee referred to in section 28 and shall appoint the membership of the Physiotherapy Standards Committee, which shall include, at a minimum, one or more:
   a) members of the Council;
   b) members of the College (including practitioners and educators);
   c) persons who are not and have not been members of the College or of the Council;
   d) members of the College of Physicians and Surgeons of Ontario, approved by the College of Physicians and Surgeons of Ontario;
   e) members of the College of Nurses of Ontario, approved by the College of Nurses of Ontario;
   f) members of the College of Medical Laboratory Technologists of Ontario, approved by the College of Medical Laboratory Technologists of Ontario; and
   g) members of the College of Medical Radiation Technologists of Ontario, approved by the College of Medical Radiation Technologists of Ontario.

30. The College shall post the following on its website:
   a) the standards of practice referred to in section 27; and
   b) a list of those members who are authorized to perform a procedure under the authority of paragraph 2 of section 4.
7. That Ontario Regulation 107/96 under the *Regulated Health Professions Act, 1991* be amended by deleting the word “or” after paragraph 7.1(2)(b), by inserting the word “or” after paragraph 7.1(2)(c) and by adding a new paragraph (d) as follows:

A member of the College of Physiotherapists of Ontario, with respect to ordering the application of sound waves for diagnostic ultrasound.

8. That subsection 6(1) the *Healing Arts Radiation Protection Act* be amended by adding the following paragraph (g), so that it reads:

6(1) No person shall operate an X-ray machine for the irradiation of a human being unless the irradiation has been prescribed by, … (g) a member of the College of Physiotherapists of Ontario.

9. That paragraph 9(1)(a) of Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding the following:

(iv.2) at the request of a physiotherapist, in respect of a test specified in Appendix E, …

10. That Ontario Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding Appendix E.

11. That paragraph 4(2)(b) of Ontario Regulation 683 under the *Laboratory and Specimen Collection Centre Licensing Act* be amended by adding the following:

(vi) a physiotherapist,

12. That PART III – PERSONS PRESCRIBED TO ORDER TESTS of Ontario Regulation 207/94 under the *Medical Laboratory Technology Act, 1991* be amended by adding the following:

4. A member of the College of Physiotherapy of Ontario.