Third Session - Thirty-Ninth Legislature

of the

Legislative Assembly of Manitoba

Standing Committee on Human Resources

Chairperson
Ms. Jennifer Howard
Constituency of Fort Rouge

Vol. LXI No. 1 - 6 p.m., Monday, June 1, 2009

ISSN 1708-6655

MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Ninth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON HUMAN RESOURCES

Monday, June 1, 2009

TIME – 6 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Ms. Jennifer Howard (Fort Rouge)

VICE-CHAIRPERSON – Ms. Marilyn Brick (St. Norbert)

ATTENDANCE – 11 QUORUM – 6

Members of the Committee present:

Hon. Ms. Oswald, Hon. Mr. Rondeau

Ms. Brick, Mr. Caldwell, Mrs. Driedger, Messrs. Dyck, Goertzen, Mses. Howard, Korzeniowski, Mr. Martindale, Mrs. Mitchelson

APPEARING:

Hon. Jon Gerrard, MLA for River Heights

WITNESSES:

Bill 13–The Medical Amendment Act

Mr. William D. B. Pope, College of Physicians and Surgeons of Manitoba

Bill 18–The Regulated Health Professions Act

Ms. Bonnie Coombs, Private Citizen
Ms. Pat Chevrier, Private Citizen
Mr. Eric Alper, Manitoba Association of School Psychologists Inc.
Mr. William D. B. Pope, College of Physicians and Surgeons of Manitoba
Ms. Kathy Doerksen, College of Registered Nurses of Manitoba
Mr. Sandy Mutchmor, Manitoba Dental Association
Mr. George Fraser, Massage Therapy Association of Manitoba
Mr. Randall Stephanchew, Manitoba Pharmaceutical Association
Mr. Kyle MacNair, Canadian Society of Hospital Pharmacists
Mr. Scott Ransome, Manitoba Society of Pharmacists
Mr. Troy Harwood-Jones, Manitoba International Pharmacists Association
Ms. Gayle Romanetz, Private Citizen
Ms. Colleen Metge, Faculty of Pharmacy, University of Manitoba
Mr. Tim Pattern, Private Citizen
Ms. Sandi Mowat, Private Citizen
Ms. Laurie Thompson, Manitoba Institute for Patient Safety
Ms. Annette Osted, College of Registered Psychiatric Nurses of Manitoba
Ms. Laureen Lipinski, Private Citizen
Ms. Colette Raymond, Private Citizen
Ms. Penny Murray, Private Citizen
Ms. Heather Milan, Private Citizen
Mr. Nicholas Honcharik, Private Citizen

WRITTEN SUBMISSIONS:

Bill 18–The Regulated Health Professions Act

Andrea Belanger, Vision Council of Canada
Sandy Mutchmor, Manitoba Dental Association

MATTERS UNDER CONSIDERATION:

Bill 11–The Highway Traffic Amendment and Manitoba Public Insurance Corporation Amendment Act

Bill 13–The Medical Amendment Act

Bill 15–the Victims' Bill of Rights Amendment Act

Bill 18–The Regulated Health Professions Act

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Clerk Assistant (Mr. Rick Yarish): Good evening. Will the Standing Committee on Human Resources please come to order.

Your first item of business is the election of a Chairperson. Are there nominations?

Mr. Doug Martindale (Burrows): Mr. Clerk, I nominate Ms. Howard.

Clerk Assistant: Ms. Howard has been nominated. Are there any other nominations?

Seeing none, Ms. Howard, will you please take the Chair.

Madam Chairperson: Our next item of business is the election of a Vice-Chairperson. Are there any nominations?

Mr. Martindale: I nominate Ms. Brick.

Madam Chairperson: Ms., Ms. Brick has been nominated. Are there any other nominations?

Hearing no other nominations, Ms. Brick is elected Vice-Chairperson.

The meeting has been called to consider the following bills: Bill 11, The Highway Traffic Amendment and Manitoba Public Insurance Corporation Amendment Act; Bill 13, The Medical Amendment Act; Bill 15, The Victims' Bill of Rights Amendment Act; Bill 18, The Regulated Health Professions Act.

We have a number of presenters registered to speak this evening, as noted on the list before you. Before we proceed with presentations, we do have a number of other items and points of information to consider. I'll ask in advance for your patience. I have a lot of pages to read here.

First of all, if there's anyone else in the audience who would like to make a presentation this evening, please register with the staff at the entrance of the room. Also, for the information of all presenters, while written versions of presentations are not required, if you're going to accompany your presentation with written materials, we ask that you provide 20 copies. If you need help with photocopying, please speak with our staff.

As well, I would like to inform presenters that, in accordance with our rules, a time limit of 10 minutes has been allotted for presentations, with another five minutes allowed for questions from committee members. Also in accordance with our rules, if a pres–if a presenter is not in attendance when their name is called, they will be dropped to the bottom of the list. If the presenter is not in attendance when their name is called a second time, they will be removed from the presenters list.

On the topic of determining the order of public presentations, I will note that we do have out-of-town presenters in attendance, marked with an asterisk on the list. With that in mind, in what order does the committee wish to hear the presentations?

Mr. Martindale: Madam Chairperson, I think we should follow our usual procedure which would be to hear out-of-town presenters first.

Madam Chairperson: Is that agreeable to the committee?

An Honourable Member: Agreed.

Madam Chairperson: We'll hear out-of-town presentations first. *[interjection]* Oh–

Mr. Martindale: Well, there's only one presenter on Bill 13. Is the committee willing to do that bill first and then Bill 18?

Madam Chairperson: Is that agreeable to the committee?

Some Honourable Members: Yes.

Madam Chairperson: Okay. So we'll hear presenters on Bill 13 first. Then we'll move to Bill 18 where we'll hear out-of-town presenters first.

A written submission on Bill 18 from Andrea Belanger of the Vision Council of Canada has been received and distributed to committee members. Does the committee agree to have this document appear in the *Hansard* transcript of this meeting?

Some Honourable Members: Agreed.

Madam Chairperson: That is agreed.

In accordance with our rules, as there are currently more than 20 people registered to speak to these bills tonight, except by unanimous consent, this committee may not sit past midnight to hear presentations. How late does the committee wish to sit tonight?

Mr. Martindale: In view of the fact that we're probably not going to get through all of them even by midnight, I would recommend that we sit till 10 o'clock and then re-evaluate at that time.

Madam Chairperson: Is that agreed by the committee that we sit until 10 o'clock and then re-evaluate?

Some Honourable Members: Agreed.

Madam Chairperson: Agreed.

Prior to proceeding with public presentations, I would like to advise members of the public about the process for speaking in committee. The proceedings of our meetings are recorded in order to provide a verbatim transcript. Each time someone wishes to speak, whether it be an MLA or a presenter, I first have to say the presenter's name. This is the signal for the *Hansard* recorder to turn the mikes on and off.

Thank you for your patience. We'll now proceed with public presentations.

Bill 13–The Medical Amendment Act

Madam Chairperson: I will now call Dr. William Pope of the College of Physicians and Surgeons of Manitoba to present on Bill 13, The Medical Amendment Act.

Do you have written materials tonight, Dr. Pope?

Mr. William D. B. Pope (College of Physicians and Surgeons of Manitoba): I do not, for this presentation, Madam Chair.

Madam Chairperson: Okay. Please proceed to–with your presentation.

Mr. Pope: Thank you, Madam Chair, Madam Minister, honourable members, ladies and gentlemen. Thank you for this opportunity to comment on Bill 13.

It was introduced at the request of the College of Physicians and Surgeons of Manitoba. It's based on our council's recognition of physician assistants as a profession and the important role that physician assistants do and will play in providing health care to Manitobans.

It's imperative that these amendments be in place to permit students in the new Master's of Physician Assistant program at the University of Manitoba Faculty of Medicine to see and learn from patients in the second year of their education program.

I very much wish to thank the minister for proceeding with this legislation, and I urge the committee to approve this bill. Thank you again.

***** (18:10)

Madam Chairperson: Thank you. Does the committee members have any questions?

Hon. Jon Gerrard (River Heights): First of all, thank you for your efforts in this regard. I would ask you to–just so that all the members here have an understanding of the proposed scope and role of physician assistants–that you provide, you know, a little bit more information about the planned scope and the extent of training.

Floor Comment: Thank you, Dr. Gerrard.

Madam Chairperson: Oh, sorry–

Floor Comment: I apologize.

Madam Chairperson: Now, I'm, I'm messing up now, so–we'll get it. Dr. Pope.

Mr. Pope: Madam Chair, Manitoba was and is the first province in Canada to register and license physician assistants. It was a real leader in this, and we've been acknowledged as such right across the country. About four months ago, I presented on our program at a national meeting hosted by the Canadian Medical Association and Manitoba received accolades from everyone for the way in which it was done, the appropriateness of it, and the success of the program.

So what a physician assistant does or is allowed to do, basically, is to work as a physician extender. The physician assistant has a scope of practice, the doctor has a scope of practice, and the physician assistant is allowed to do anything that he or she is competent to do and the physician is competent to do in a specific job description that is approved by me or by one of my registrars. The physician assistant must have, in fact, liability coverage and is registered with us as an associate member.

What this bill does is to reorganize the system. There are two classes of physician assistants, effectively. There are those who have trained in a physician assistant program, either in Canada or in the United States of America, and they have more quasi-independence in the scope of their practice and the supervision that's required of them. And then there are the clinical assistants who are those from other jurisdictions, and Manitoba very wisely, I think, has included more than just those who have learned, who have trained in a formal physician assistant program. So those individuals may be anyone who is a registered member of a health-care profession in Manitoba, an international medical graduate in Manitoba, or someone who is at the highest level of the emergency medical technologists.

What this bill does is two things. Firstly, it creates the opportunity for the Master's of Physician Assistant students to be able to see patients because, at the moment, although we can have registered and licensed physician assistants see patients, there's no room for students, as such, to do so. This recreates an educational register for the College of Physicians and Surgeons and on that educational register may be medical students, residents who are not yet fully able to practise, or the physician assistant students. It allows them all the opportunity to work with patients to learn and to be qualified prior to certification. The other thing it does is it broadens the scope of practice of the physician assistant people who can come in, not just to Manitoba but to other provinces. So we

feel very strongly that this will help to support and embellish what is presently recognized as an excellent national program, and we are very, very pleased to be able to work with Manitoba to make this happen.

Madam Chairperson: Thank you.

Mrs. Myrna Driedger (Charleswood): Dr. Pope, I just want to thank you for the college bringing that idea forward. It certainly is something that's been very successful through the armed forces in Canada and the United States, and in the United States it's certainly gone back decades and decades, as I'm sure it probably has in our Canadian forces. And it's good to see that kind of innovation because I think the challenges as we go forward in finding the number of health-care personnel we need is going to become more and more challenging. So this is certainly an innovative step for Manitoba to take and, you know, one that we are supportive of, so thank you.

Hon. Theresa Oswald (Minister of Health): Thank you, Dr. Pope, and for that excellent and concise overview; I think I'll borrow it in future when explaining what does a physician assistant do. Thank you for your leadership on this matter and for being here tonight.

Madam Chairperson: Thank you, Dr. Pope.

Mr. Pope: Thank you.

Bill 18–The Regulated Health Professions Act

Madam Chairperson: As agreed to, we'll move on to out-of-town presenters for Bill 18, and we'll start with Greg Skura of Super Thrifty Drugs Canada. Is Mr. Skura in attendance tonight? Mr. Skura? Not seeing him, his name will drop to the bottom of the list.

Next out-of-town presenter I have is Bonnie Coombs. Is Bonnie Coombs here tonight? Yes. Do you have any written material for the committee tonight, Ms. Coombs?

Ms. Bonnie Coombs (Private Citizen): I do have written material, but I don't have it right now. It's coming.

Madam Chairperson: Okay.

Ms. Coombs: All right, by the end of the meeting you'll have it.

Madam Chairperson: So when it arrives we'll distribute it to the committee members.

Ms. Coombs: Very good. Thank you.

Madam Chairperson: Go ahead with your presentation.

Ms. Coombs: Ladies and gentlemen, thank you for hearing my presentation, and I do appreciate the fact that you've allowed me to speak early in the, the program, as it could go on for a while.

My name is Bonnie Coombs, and I wish to make a presentation as a private citizen in support of Bill 18 as currently written. By way of background, I am a pharmacist and have been one for 38 years, having practised about 23 years in retail and the last 15 in long-term care. I have been directly involved in the development of the profession in various roles the last few years. I have–having served two years on the board of the directors of the Manitoba Society of Pharmacists. During that time I served as a by-laws chairman and as a government relations chairman.

I've been actively involved with the review of drafts 1, 2 and 3 of the Regulations Discussion Document. Now, while on the board, I was involved with developing the questionnaires that were sent to the members regarding this document, and it was through the compilation of the results of these questionnaires, the discussion document feedback, the information generated from the many sessions conducted, that formed the basis of the 13 position statements that were developed by MSP in response to the document.

I also chaired one of the subcommittees appointed by the Manitoba Pharmaceutical Association to review one of the more contentious areas of the document, and I took part in the retreat facilitated by the PricewaterhouseCoopers and funded by your government in the spring of 2009 to make progress on all outstanding issues.

Having spent the last two-and-a-half years reviewing the regulations document and listening to the opinions of members throughout the province, I cannot support any amendments which would remove the pharmacist's right to vote directly on changes to the regulations that govern the profession and the code of ethics. The prevailing perspectives of pharmacy have not changed since Bill 41 was amended and approved in December 2006. The ability to vote on the regulations and the code of ethics has been broadly supported by the profession. The pharmacists of Manitoba actively advocated for change of that first draft of the regulations and, when that change was not forthcoming, soundly defeated the passage of the regulations in March of 2007.

Now, since that time, countless hours have been put in by a very broad spectrum of pharmacists; rural, city, hospital, chain drugstore and independent pharmacists, and looking for that common ground. Now, many of the issues have been satisfactorily addressed, however, at this time another draft has yet to be brought before the membership.

MPhA, the licensing body of pharmacists, contend that their responsibility is to the safety of the public. This is the reason given for lobbying for removal of the pharmacists' right to vote on the regulations. Now I hope to address this issue to your satisfaction this evening. It has always been the contention of all pharmacists that the safety of the patient is their primary concern. This concern has not changed in over 125 years of pharmacy practice in Manitoba.

Pharmacy is the only health-care profession that the public has direct access to without making an appointment and without paying a fee. Imposing restrictive, unsupported regulatory changes on a profession without the approval of the majority of the members could ultimately be problematic for the very people that we are mandated to serve. We are different than other health-care professions in this regard. Now with patient safety as a primary focus, expanded roles for the pharmacist and technician are possible but they must be rolled out in a manner that can be safely practised, both in the community as well as the hospital.

Pharmacists are responsible, accountable and liable for all the prescriptions that they fill. As the pharmacy profession focuses more on qualitative patient needs, much of the actual dispensary work is being done by a technician. However, it is still the individual pharmacist who is ultimately responsible for the work done by the employees whom they supervise. This fact alone ensures a degree of safety practised by our profession.

***** (18:20)

Pharmacy practice has found itself increasingly involved with organizations such as the Canadian Patient Safety Institute, Safer Healthcare Now! campaign, medication reconciliation programs, Manitoba Institute for Patient Safety, Accreditation Canada, Medication incident awareness, and many others. And I mention these just so that you will have an idea of what the, the pharmacist out there is dealing with in terms of safety and their patients on a daily basis.

Involvement in these programs promotes the awareness of patient safety and formalizes the activities that pharmacists have been actively doing. It is important that a set of regulations are produced which are progressive and widely supported. The regulations will dictate how pharmacy is practised in the future, so it's vital that they're pertinent to all areas of practice, and, again, I stress all areas, hospital, community, retail, long-term care, urban and rural.

Allowing members to retain the right to vote on the regulations will eventually lead to a set of regulations that will be approved by and supported by the majority of the members. It will be a set of regulations that all members can work with. Because these regulations will determine the future of pharmacy practice in Manitoba for many years to come, it is the collective goal of all pharmacists and pharmacy organizations to produce regulations which are progressive and, as I said, and I cannot repeat often enough, widely supported.

In closing, for the reasons given, I support Bill 18 in its current version and would not support amendments which would remove pharmacists' long-standing right to vote.

Madam Chairperson: Thank you, Ms. Coombs. Are there any questions?

Hon. Theresa Oswald (Minister of Health): Not a question, Madam Chair, but a comment. I want to thank you very much for an articulate point of view on what is anticipated to be a lively debate this evening. I thank you for coming in from out of town and your commitment to the people of Manitoba.

Hon. Jon Gerrard (River Heights): Thank you, Bonnie. You know, I gather that one of the significant reasons why there hasn't been sort of a coming together is the difference in terms of what happens in the community versus in the hospitals and the attempt or the need to make sure that the regulations fit both places. Is that right?

Ms. Coombs: I would say that is, is partly right, yes, but we're working on this. We've come together on many, many issues. We're–I think we're much closer. There were 13 contentious areas at one time. Subcommittees were appointed for–to address six of these and reports were submitted from these committees, and they were, they were filled by members of–the pharmacists in Manitoba.

We've come–and we've had this retreat, as I mentioned, with PricewaterhouseCoopers and we've

come much closer on many issues. So it, it is just down to a few, but you're right, that is one of them.

Mrs. Myrna Driedger (Charleswood): Thank you very much for your presentation. I just had a question based on your comments about the number of times drafts of regulations have been developed. Did you indicate that they were I guess drafted three different times? Did I hear that accurately?

Ms. Coombs: Yes, there were three drafts.

Mrs. Driedger: Am I to understand, then, that even after the third draft there was still, I guess–

Floor Comment: Well, it was onl–I'm sorry, I didn't mean to interrupt.

Madam Chairperson: Ms. Coombs.

Ms. Coombs: –if I can clarify.

Madam Chairperson: That's okay. Ms. Coombs.

Ms. Coombs: It wasn't voted on until after the third draft.

Madam Chairperson: Seeing no other questions, I thank you very much for your presentation tonight.

Next we'll move to Mel Baxter. Mel Baxter. Is Mr. Baxter here this evening? Not seeing him in the room, his name will drop to the bottom of the list.

That completes the names I have for out-of-town presenters, so we'll move back to the top of the list, and the first name on my list is Pat Chevrier.

Welcome, Ms. Chevrier. Do you have written copies? I see that you do.

Ms. Pat Chevrier (Private Citizen): I sure do.

Madam Chairperson: Please pass them to our clerk. You can start whenever you're ready.

Ms. Chevrier: Okay. I thank you for this opportunity to, to state my, my cause.

My name is Pat Chevrier, and I'm the Manitoba representative of an informal group of medical doctors, chiropractic stroke victims and their families from across Canada.

Personal experience and research, specific to spinal manipulation and chiropractic has convinced our group that manipulation of the cervical vertebrae of infants, children and adults is a dubious, over-utilized primary treatment technique that poses a significant risk of arterial damage and stroke, and is a clinical procedure that does not conform to uniform scientific and therapeutic standards amongst all practitioners of spinal manipulation.

The risk versus benefit ratio of cervical manipulation is difficult to quantify and, considering the horrendous lifelong, life-altering consequences of arterial damage and stroke, I am respectfully asking this committee to prohibit cervical manipulation, in particular, high neck, high velocity, low amplitude cervical manipulation. High velocity, low amplitude cervical manipulation is an abrupt tilting, pulling and twisting of the vertebrae in the neck. The thrust used can be equated to 38 percent of the force used in a hanging. It takes the patient by surprise and cannot be resisted by the patient. It's the quintessence of chiropractic and one of the primary treatment techniques.

Now, chiropractic is a belief system that the vertebrae is somehow the master of the human body, and that misalignment of the vertebrae, called a vertebral subluxation, is the cause of ha–of ill health and body malfunction. Chiropractic promotes the manipulation of the cervical vertebrae to remove the vertebral subluxation, release the body's innate intelligence and permit the body to self-heal, and that explains why most chiropractors will manipulate the leck–the neck repeatedly to attain and maintain wellness, to treat non-musculoskeletal conditions and, as chiropractic literature explains, to treat pain in parts of the body totally unrelated to headache or neck pain. They will manipulate one's neck literally for a pain in the butt. I will add that there is no medical or scientific evidence to support the use of cervical manipulation for the above reasons.

At attachment 1 is the diagram of the arteries. The vertebral arteries run up both sides of the back of the neck, passing through the holes in each side of the neck vertebrae. At the second cervical vertebrae they begin to make a slight horizontal turn, and at the first vertebrae they make a very abrupt horizontal turn and, it is at this point, the first and second cervical vertebrae, that with a rapid pulling, stretching and twisting of the vertebral artery during neck manipulation that the delicate arterial lining is subject to tearing, medically known as a dissection. The damaged artery will bleed causing the arterial walls to bal–to balloon and block the blood flow to the brain causing a stroke and/or cause clot formation to occur. And at some point after the manipulation, and it can be hours, days, weeks and even months later, the clot or parts of the clot can be dislodged, ultimately resulting in a stroke.

Now, attachment 2 is a 2002 con–statement of concern from 62 Canadian neurologists to all practitioners of spinal manipulation, provincial ministries of health and the Canadian public regarding a debilitating and fatal damage manipulation of the neck may cause. These same neurologists call for ministries of health to conduct full public inquiries into the dubious claims being made as to the conditions that may benefit from cervical manipulation.

Where there's smoke there's usually a fire, and for over half a century there has been a smouldering inferno surrounding cervical manipulation and stroke. Sixty years of scientific studies conclude that manipulation of the cervical vertebrae can and does cause arterial damage and stroke, and that the exact number of dissections and stroke is unknown and most likely underestimated due to underreporting and misdiagnosing of adverse events.

***** (18:30)

Attachment 3 is a very well-respected and much-quoted Canadian study: Chiropractic Neck Manipulation and Stroke. In fact, chiropractic associations refer to this study throughout their patient handouts, and you have the handouts. Unfortunately–and I am obligated to say this–the quotes in these patient handouts are incomplete, inaccurate and most definitely misleading. This study, Chiropractic Manipulation and Stroke concludes that patients in the under-45 age group, if attending to a chiropractor for cervical manipulation, are five times more likely to suffer a dissection and stroke than those in the same age group that did not have cervical manipulation. And, in that under-45 age group presenting with dissection and stroke-like symptoms, patients are five times more likely to have had three or more cervical manipulations in the week proceeding their stroke.

As well, this study also states the following points: (1) The association between cervical manipulation and dissection has been reported with increasing frequency in the last 20 years coinciding with the rise and popularity of chiropractic; (2) It is up to the practitioners of this technique to demonstrate the evidence-based benefit of cervical manipulation and to define exactly when the benefits of intervention outweigh the risks.

Now, the Canadian Chiropractic Clinical Practice Guidelines, page 172, section 4.1, state, and I quote: Acute neck pain in adults is generally regarded to be self-resolving. They then go on to say: And 90 percent of acute and chronic neck pain will self-resolve in six weeks.

Now, point three of the study says: There is no premanipulative test to determine who is at greater risk of suffering arterial damage and stroke from cervical manipulation.

Again, those same Canadian Chiropractic Clinical Practice Guidelines, page 188, section 17, state: There is no premanipulative test to determine who is at greater risk of dissection and stroke.

In 1986, the College of Physicians and Surgeons of Manitoba advised doctors to warn patients about the risks of cervical manipulation after it was found that in the previous three years, six cases of brainstem injury resulted in permanent paralysis, and this had occurred within Manitoba.

And in an e-mail to me from the College of Manitoba Physiotherapists, it reads that most physiotherapists in the province no longer practise cervical manipulation, in particular, high neck manipulation due to the inherent risks.

And in a conversation with a Winnipeg neurologist at the Health Sciences Centre, I was informed that it is now standard practice when young adults present with dissection and stroke-like symptoms to routinely question if there has been a history of cervical manipulation.

Three young Canadian women, all under the age of 45, have died after numerous cervical manipulations, and all coroners' reports in the three deaths concluded death was the result of arterial tearing, bleeding and stroke, and all recommendations centred around chiropractic and cervical manipulation.

In June of 2008, Sandra Nette of Edmonton launched a massive class action lawsuit against her chiropractor for selling inappropriate and non-beneficial spinal manipulations, the Alberta College and Association of Chiropractors for failing to regulate cervical manipulation and the Alberta Ministry of Health for failing in its role to protect the public. Sandra suffered a devastating stroke after numerous neck manipulations, all in the name of wellness care.

Now, to conclude, the bad news is that the number of dissections is increasing with the popularity and availability of chiropractic, and dissection and stroke from cervical manipulation can cause horrendous lifelong, life-altering consequences

for its victims, as well as enormous long-term costs to our health-care system.

The good news, the good news is that dissection and stroke from cervical manipulation is entirely preventable. I respectfully request that the public be protected. Please, somehow, prohibit cervical manipulation.

And I'm just going to add, remember the Canadian Chiropractic Practice Guidelines state 90 percent of acute and chronic neck pain will self-resolve, and there is no premanipulative test to determine who is at greater risk. I thank you for listening to me.

Madam Chairperson: Thank you, Ms. Chevrier. You timed that perfectly. It is perfect.

As for questions, I have the honourable Minister of Health.

Ms. Oswald: Thank you for your presentation, Ms. Chevrier. It's nice seeing you again.

I want to comment that the very nature of The Regulated Health Professions Act, in taking the reserved act approach, is I think going to be useful and, and the creation of the advisory council to whom matters such as these in a ex–expedited way, I would add, can be referred to discuss and advise what we've seen in other jurisdictions become a pretty heated debate. I think it will–the function and the structure within the act will provide for a, a very sensible discourse on this issue. So I'm encouraged on this topic and the going forward of this act.

I just wanted to ask, for clarification, when we have spoken in the past, you have made a comment about chiropractic in general, and I believe, as articulated in your paper, you're concerned about a specific manipulation. That's clear. But I wondered if you had any interest in clarifying your points of view. We've seen recently in other jurisdictions, or one in particular, the delisting of chiropractic in its entirety. I wonder if you might wish to comment on your point of view on that.

Ms. Chevrier: Well, I'm certainly not anti-chiropractic, and I'm not saying that everything a chiropractor does is, is not worthy. But I'm very much anti, anti-chiropractic neck manipulation. And, in reality, Manitoba Health has no idea how many neck manipulations a chiropractor is performing, because when a chiropractor bills Manitoba Health, they're–the billing codes only indicate the condition of the patient, not the treatment, not the diagnosis.

So, well, I would like to see all chiropractic delisted, deinsured, but that's my opinion.

Madam Chairperson: Dr. Gerrard.

Floor Comment: Did that answer the question?

Madam Chairperson: Ms. Coombs? Ms. Chevrier, sorry. You have to repeat yourself. I didn't recognize you.

Ms. Chevrier: I was wondering if that, if that answered the question.

Ms. Oswald: I thought it was a fine answer.

Ms. Chevrier: That's fine. Thank you.

Mr. Gerrard: You quote in your presentation the fact that there were, I think it is, six incidents reported in 1986. Do you have any more recent data since then for Manitoba?

And the other thing I wanted to ask you was, was there a particular incident which got you looking at this in particular?

Ms. Chevrier: I certainly don't have any more data from the College of Physicians and Surgeons.

A family member suffered a stroke after numerous cervical manipulations over a period of four years, and when I approached the Manitoba Chiropractors' Association, they just said, not possible, simply not possible. That kind of damage does not occur from cervical manipulation.

So I really do believe that the chiropractic community minimizes the risks involved in cervical manipulation.

And those handouts that I have attached, if you read them carefully and if you read the study that I've attached carefully, you will see how they do not quote that study accurately. The public is not given enough–is not given the proper information to make informed consent.

Madam Chairperson: Thank you, Ms. Chevrier.

Seeing no other questions, thank you for your presentation.

Ms. Chevrier: Yes, thank you very much.

***** (18:40)

Madam Chairperson: Thank you.

Next we have Eric Alper from the Manitoba Association of School Psychologists.

You can just give your written presentation to the clerk. Thank you. You can start whenever you're ready.

Mr. Eric Alper (Manitoba Association of School Psychologists Inc.): Thank you.

Thank you, Madam Chairman, minister and members of the committee.

My name is Eric Alper and I am the immediate past-president of the Manitoba Association of School Psychologists. Along with me in the room is Dawn Hanson, our recently elected president. I thank the committee for the opportunity of presenting MASP comments this evening.

We have organized our presentation around five topics or themes.

Firstly, what is MASP? MASP is the acronym for the Manitoba Association of School Psychologists, an organization founded in 1981. MASP has 90 members who represent the majority of psychologists who work in schools in the province of Manitoba.

Psychologists who work in schools include both Master's and doctoral prepared practitioners. Psychologists who work in schools provide a broad spectrum of psychological and mental health services such as psychological assessment, diagnosis of child and adolescent disorders and treatment of learning, behavioural and social-emotional disorders.

School-based psychologists are certified by Manitoba Education, Citizenship and Youth, MECY, as are speech language pathologists who work in schools. Speech language pathologists are certified by MECY but as providers of health services must also be licensed by their regulatory body. This is not currently true for school-based psychologists who are exempted from regulation under the current psychol–psychologists act.

Secondly, why MASP is interested in The Regulated Health Professions Act, RHPA: RHPA will result in a new regulatory body for psychology, a college of psychologists. Since 1993, MASP has been working with the legislative unit of Manitoba Health to help develop a new psychologists act. This process was interrupted by the decision on the part of government to develop umbrella health profession legislation.

Thirdly, our general comments about the RHPA: The Manitoba Association of School Psychologists congratulates Manitoba Health for developing legislation entitled The Regulated Health Professions Act. MASP has an overall positive profess–impression of the wording and organization of this proposed new legislation. Specifically, we support the focus on public protection, consolidation of the various health acts under one umbrella act, the reserved acts approach, and the removal of barriers to interdisciplinary practice.

Fourthly, what are the potential issues of concern to MASP about the RHPA? There are two areas we wish to identify as it relates to the future college of psychologists; firstly, the exemption provision section 5(2), person or class of persons may be exempted. MASP does not want exemption status in the new college of psychologists for Master's-trained psychologists. The current psychologists act has not allowed for full registration of Master's-prepared psychologists in the regulatory body.

Full membership, that is regulated member under the RHPA, of both Master's- and doctoral-prepared psychologists in the future college of psychologists is essential to reflect the current scope of practice reality; that is, psychological assessment, diagnosis, therapy and psychosocial intervention in Manitoba. In the interest of public protection and increased public access to services, all providers of psychological services must be regulated. This is not currently the case.

The second area of potential concern is associate member provision, section 26, 28, register of regulated associate members. MASP finds the term regulated associate member to be an inappropriate term for freg–for future use in regulations pertaining to the new college of psychologists. By definition in the RHP–RHPA umbrella legislation, Bill 18, a regulated associate member would not hold full membership in a college. Most unregulated psychologists in Manitoba currently engage in all or most of the practice activities as fully regulated psychologists.

The use of the term regulated associate member in the register of the new college of psychologists would be inaccurate and confusing to the public. The use of regulated associate member has the potential to reduce and restrict the availability and scope of psychological and mental health services in our province. If Master's-prepared psychologists are not full members of the college, psychological and mental health services to children and families in the province would be adversely impacted as

Master's-prepared psychologists currently provide the large majority of these essential services from the psycho–psychological community.

Finally, RHPA and regulations for a new college of psychologists is urgently needed. The deputy minister of Health established the Interdepartmental Advisory Committee on The Psychologists Registration Act in March 2000, and a discussion paper with specific recommendations was released in July 2002.

The profession of psychology has been in a state of uncertainty and confusion that has not served either the profession or the public well. MASP has noted that an act governing social work, Bill 9, has passed first reading in the Legislature. This legislation will require that social workers from all practice settings be registered within this one act. MASP is confident that this inclusive approach will also work for the profession of psychology in Manitoba.

On the next page, for your information, we provided a table with the heading, number of psychologists registered in prairie provinces, that takes a look at Manitoba, Saskatchewan and Alberta based on the 1998 census–sorry, the 1996 census– and 2006 census, and looking at the years '98 and 2009. And, as you'd see before you, in Manitoba the number of psychologists, fully registered psychologists, in Manitoba in '98 was 150; currently it's 170. The number of psychologists per 100,000 has remained about, basically the same. It's gone up one, to 15 per 100,000.

In Saskatchewan, in '98, there was 71 psychologists, which was the lowest at the time among all provinces and territories when you consider proportion surface in the province, seven per 100,000. Currently, there are 393 fully registered psychologists. That's a ratio of 41 to 100,000.

Why the large change? Because Saskatchewan decided to proceed with a new psychologist act, which was proclaimed in 2002, that included all psychologists, both master's and doctoral prepared, whereas formerly it was only doctoral prepared.

The result is that our province, Manitoba, has the lowest number of fully registered psychologists per population in the country.

And Alberta, as you see, has a large number. In '98 it's 1,726; now it's over 2,000, and the ratio stays the same, however, the numbers have increased and, of course, the population in Alberta over the last number of years have–has increased significantly. So they have kept paced with the population growth there.

That concludes my presentation. I would welcome your questions.

Madam Chairperson: Thank you, Mr. Alper.

Ms. Oswald: Thank you very much for your presentation.

Just a comment. You've articulated a couple of issues–three main ones, I think–in a very clear fashion, and we know as, as we go forward, each profession is going to find under the umbrella of this legislation situations such as these. And the intent of the legislation, of course, is not to inhibit one's ability to practise and, more importantly, inhibit the public's acc–the public's access to professionals.

So, as we go forward, perhaps in a regulatory way, these issues are going to be able to be addressed, I believe, and I want to thank you for so clearly articulating them for us here this evening. Thank you for coming.

Madam Chairperson: Seeing no other questions, I thank you for your presentation, Mr. Alper.

Next on my list, I have Dr. William Pope from the College of Physicians and Surgeons of Manitoba. Welcome back, Dr. Pope. You can begin whenever you're ready, sir.

Mr. William D. B. Pope (College of Physicians and Surgeons of Manitoba): Thank you, Madam Chair.

So, Madam Chair, Madam Minister, honourable members, ladies and gentlemen, my name is Bill Pope and I am the registrar and CEO of the regulatory body for medicine in Manitoba, the College of Physicians and Surgeons. Thank you for the opportunity to speak to this bill.

Firstly, I do want to underline that my council has authorized me to say that we strongly support this act. In fact, many requests that we have made have been included in the act, and we very much appreciate that this will permit us to better ensure the safety of the public, which is our, indeed, our prime responsibility.

We also greatly appreciate the willingness of Manitoba Health, and especially the legislative unit, to receive the concerns we raised from the white paper that was published early this year and, Madam Minister, if I might, I would like to acknowledge

particularly Ms. McLaren as she has now normally, somewhat retired, but the work that she and Ms. Miller *[phonetic]* have done on this has been exemplary. Their billing–their willingness to work with us has been extraordinary, and we're very fond of them. So thank you for all the work that they do.

***** (18:50)

There were a number of very important changes that were made from the white paper to Bill 18, which reflected the issues that we presented and, again, thank you for this facilitative approach to the introduction of new legislation.

There are three items that I'd like to raise of some concern still to the College of Physicians and Surgeons. The first relates to section 120, and this is the section that requires the publication of the name of any physician found at fault by an inquiry panel. We have made several previous submissions about this, and we're exceedingly concerned that this may harm an innocent third party. The example that I have is if a physician in a small community is suspended or erased because of sexual misconduct with a patient, the community is often enraged against the victim who may be seriously disadvantaged by having made the report to the college. My Ontario colleagues have indicated this has actually occurred in Ontario, where the same legislative clause exists. Please do note that this request does not refer to the physician or a risk to the physician's family. Council accepts the publication of all names except when there is a risk to an innocent vulnerable third party.

The second section is subsection 101, sub 2. This section requires the investigation committee of the college to provide a copy of the investigator's report to the physician and grants the physician a right to make written submissions about the findings in the report. We fully support the right of a physician who is the subject of an investigation to know the allegations made against him or her and to be afforded an opportunity to make written submissions in relation to those allegations. This protection for physicians already exists in section 102, sub 2. We also fully support the legal requirement to provide a physician with full disclosure when the investigation committee offers a censure or refers the physician to inquiry. The requirement in subsection 101, sub 2, goes beyond these rights and creates a new obligation of disclosure and a new obligation to afford an opportunity to make a written submission on the disclosed material before the investigation committee has a chance to discuss it and to make its decision.

Although the case law depends upon the particular process under review, generally speaking, the courts have based the differences and rights granted to a physician upon the difference in function at the investigation stage versus the adjudicative stage. At the adjudicative stage, the physicians must be given and are given all of the protections of procedural fairness, however, at the investigation stage the courts have not imposed the same procedural fairness requirements excepting only when a tribunal at the investigative stage has the authority to make these types of decisions.

It's important to bear in mind the rationale of the court's reluctance to impose procedural fairness requirements at investigative stage. Courts have recognized that the college's purpose is to protect the public interest and providing the physician with extensive rights at the investigative stage would work contrary to the public interest.

As noted above, we fully support anyone's right–the, a member's right to make a written submission, however, the added requirement of the committee receiving submissions following disclosure of the investigator's report grants physicians rights appropriate for the adjudicative stage, not the investigative stage of the proceeding.

So, to summarize, fairness to a member in an investigation does not require that an investigator's report be forwarded to the member during the investigation. It does require full disclosure to a member once a decision has been made and forwarded for possible discipline. This is what we mean by the investigative versus the adjudicative stage. In our opinion, it would also be unfair to the complainant to provide such a respon–such an option only to the physician. We suggest that this is like asking the police to release information to a suspect immediately upon opening an investigation, rather when a charge is laid.

The third item is a government's issue. We are somewhat concerned that there appears to be a different process being introduced for only one of our sister colleges in this, in this bill, and that regulatory authority there is already discussing the matter this evening, so I won't say anything more. But we do believe that the same processes should apply to all and that those processes should support a regulatory authority's council's responsibility to

govern as it has been elected so to do. So this is philosophical and not specific.

So, finally, in conclusion, medicine has actually requested that we be the first health-care profession to come under this new act. We are excited about the opportunities to review all we do and be able to review what we do, why we do it and how we will do it for the next two or three decades. We very much look forward to working with the department to provide a new system that will best serve Manitobans in the future. Thank you.

Madam Chairperson: Thank you very much, Dr. Pope.

Ms. Oswald: Thank you, Dr. Pope, first of all, for acknowledging Ms. McLaren and the legislative team and all the incredible work that they've done. I couldn't have said it better myself, and won't even try because you did a lovely job.

Secondly, I want to congratulate your college and, indeed, all colleges for the extraordinary effort that has gone into the discussion of this legislation. You are to be commended for that and for volunteering to go first, a bold move.

Lastly, on the very serious issue of naming prof– health professionals who have committed an infraction. It's been the subject of some debate over the last weeks, and the example that you've articulated in your paper I believe is clear as day. Who would not want to protect somebody in a community that might have retaliation against them when, indeed, they were the victim?

There is cynicism out there, though, as I know you are aware, about colleges potentially being protectionist about their members. This is a label, I think, that is given unfairly sometimes, but it comes from somewhere.

How is it that you could assure the public that every time an unflattering situation occurred in a doctor's professional life, that we want to protect an innocent third party, that wouldn't be trotted out in the name of not unveiling that information? I know that when I speak to patient safety advocates, they can see no reason for doctors to be protected, you know, from a sexual misconduct, no less.

How can the public feel sure that colleges will not just protect their own?

Mr. Pope: Thank you for the easy question, Madam Minister.

I think the issue of the comment might reflect– be reflected by a process that defines the reason within it for not publishing and, certainly, that was always done anyway. So you–the act does allow some degree of, of, of word-smithing the reports that are given anyway, as I understand.

As you asked me, I think the issue would be, is there some way in which the disciplinary report could identify not the name of the person but the fact that the person who is the victim there is the one who is being protected. And then the real question is: If that is the case, do people not trust the regulatory authority? And I don't know that there's much more I can say to that, because I know that you do stand up for us regularly on an ongoing basis.

Mr. Gerrard: Just several quick points. One, in your first point, could you not name the physician but not name the person who brought forward the complaint? It has occurred to me that the college has moved in terms of naming people who have committed previous errors, but the college could also play a role in naming physicians who are doing exemplary best practices, and I think that there could be a larger role in that area.

And, lastly, in terms of this obligation of disclosure, you suggest that this is like asking the police to release information to a suspect immediately on opening an investigation, and, yet, my interpretation of this is that the release of material to the physician–or, as you point out, if it's to the physician, it should be to the complainant as well–would be immediately before the final report, not at the beginning of the investigation. Isn't that the intent of this?

Mr. Pope: Let's try the first one. The difficulty is that this is a series of small communities, and Manitoba, of course, it's one degree of separation for every human being for the rest of us in this province, no matter where we go.

In small towns, it's even more the case. And so, although the doc–the phys–the victim's name would never be published by us, if a physician is publicly in some way suspended or erased in a small community, that community knows who the person is who has made the complaint. Nine times out of 10, the scuttlebutt there is *[inaudible]* And so, despite the fact that the person is not named, the community still goes against–is ra–enraged against and harmed, and may actually harm, but certainly will be–treat very badly–the person who was the victim who has reported.

***** (19:00)

And I think the concern that this will result in women being very afraid to make these comments back is a serious one. It already is the case. Sometimes, when our complaints investigations staff receive calls, and we usually try to have a person of the same sex take that call to be supportive, it can sometimes take three, six, sometimes, sometimes a year before the victim feels comfortable coming forward. And we do tell the person that if it comes to an inquiry, the information she has will come–and it usually is a she–will come before the inquiry panel. But we try to do everything we can to protect the person who has brought that forward, and in a small town, really, there is no privacy. So I think that's, that's the concern that we have about this issue.

Best practices, I think it's a very good idea. The doctors in Manitoba does that. I noticed that the Ontario college each year publishes one of its bimonthly journals in which it actually identifies, for example, the large percentage of physicians or members who work for the college. That's terrific, and I think it's a very good idea and I will seriously take it under consideration, because it's rare for physicians to have a letter of accolade from their registrar. In fact, even some of my closest friends indicate that when they get a letter from me, one of the purple letters, even if they know that it's a–an honorarium cheque, it still may take them a day or two to open the letter, and so, doing something that will be positive for members is a very good idea. Thank you.

Can you do me the third one again please? 'Cause that was the toughest.

Madam Chairperson: I'm sorry, the time for questions has actually expired. So I thank you very much, Dr. Pope.

Mr. Pope: Thank you.

Madam Chairperson: Next on my list I have Laurie Thompson of the Manitoba Institute for Patient Safety. Is Laurie Thompson here? Laurie Thompson? That name will drop to the bottom of the list.

The next name on my list is Kathy Doerksen of the College of Registered Nurses of Manitoba. You can begin whenever you're ready.

Ms. Kathy Doerksen (College of Registered Nurses of Manitoba): Thank you, Madam Chair, Minister of Health and committee members.

My name is Kathy Doerksen. I'm a registered nurse and the current president of the College of Registered Nurses of Manitoba.

The College of Registered Nurses of Manitoba is pleased to have this opportunity to address this committee and present on this legislation. The college is a professional regulatory body for more than 12,000 registered nurses, nurse practitioners and graduate nurses in Manitoba. We regulate registered nursing in the public interest on behalf of the people of Manitoba.

I would like to begin my brief remarks by commending Health Minister Theresa Oswald and her department for the process which was undertaken to develop this legislation. The last time our college was before a standing committee presenting on a government bill, we talked about a lack of consultation. This time, it is important to recognize that this minister took a very consultative and inclusive approach by involving the regulated health professions in the development of Bill 18.

We are also pleased to note that many aspects of our current registered nurses act are carried forward into this piece of legislation. At the College of Registered Nurses of Manitoba we are very clear that our mandate is to protect the public through the regulation of registered nursing.

We are also fortunate to have benefited from participation of public representatives on our board of directors and committees. The public representatives bring a perspective that enhances our ability to perform our work. As part of this consultation on the legislation we offered a number of recommended revisions, suggested changes and questions for clarification. We also note that much of our feedback resulted in changes and revisions to this bill. We believe these revisions added value to the legislation and were pleased to assist in this regard.

That said, there are a few areas we would like to call the committee's attention to. The bill before you provides for the college's council to be made up of at least one-third public representatives, but has the minister making all of the appointments, in section 13(2). There is provision, in section 13(3), for the minister to permit the council to make one or more of the public appointments. We find that wholly inadequate. Our current act shares the ability to appoint public representatives equally with the minister. Our board already appoints half and the minister appoints half. We have a well-developed appointments process utilizing an appointments

committee of the board, and it is a process which has served us well. We note that the bill contains the provision, in section 179(1)(b), whereby the College of Physicians and Surgeons council will appoint half of their council's public representatives and the minister will appoint the other half. Given that this mirrors our current process, we would like to have a similar provision in the bill with the same requirement.

Members of the committee likely know that the college's board currently has the legislated authority to make decisions regarding nursing education programs. It is a responsibility we take very seriously. This bill adds a step to the approval process in section 138 requiring meaningful consultation with both the Minister of Health and the Minister of Education prior to making any decisions regarding education programs. While we are agreeable to consult with both ministers, we have asked that a time parameter be added to this clause to ensure that it is enabling in nature and it does not prevent decision making from occurring. We would therefore suggest an amendment by adding to section 138 the following language: If one or more of the ministers has failed to provide comments within three months of the date the college provided written notification of a pending decision, the council may proceed with their decision making as if the consultation had occurred. This would ensure reasonable timeliness in the decision-making process.

Our next point relates to the make-up of the Health Professions Advisory Council in part 10 of the bill. Section 145 of the bill prohibits a member of a regulated health profession from being a part of that council. Given that the duties of the advisory council include making recommendations re–regarding such topics as reserved acts and who may perform an act and the continuing competence programs established by colleges, it seems counterintuitive to restrict any regulated health professional from being a member of the advisory council. The very tenant of self-regulation is that regulated members are in the best position to make decisions about competence and practice-related issues. Section 145, subs–(b) appears to clearly fly in the face of this and is inconsistent with other aspects of the bill. We strongly recommend an amendment that removes clause (b) from section 145.

We agree and support that the mandate of the colleges is, as outlined in section 10 of the bill, to serve the public and that the protection of the public takes primacy on all matters. With that in mind, we would like to raise a concern regar–regarding how the code of ethics and standards of practice as it relates to individual members are approved under part 15 for pharmacists. Under the bill, our college councils, which are charged with the mandate of protection of the public, will approve and adopt both a code of ethics and standards of practice. We wholeheartedly support and endorse that approach as we firmly believe it protects and safeguards the public interest. Under part 15 of the bill, the college of pharmacists will have its council approve and adopt the code of ethics and standards of practice, but must then take an additional step of having their membership approve both documents before they take effect. The bill clearly states that the council is required to act in the public interest; this is not a requirement by extension of all members of the college. We strongly recommend that this inconsistency be addressed through speedy amendment to part 15 of the bill.

These are the comments we would like placed on the record regarding this bill. I want to reiterate that we have a small number of recommended changes, but they are changes we feel strongly about. We do commend the efforts of the minister and her department in the development of this legislation.

Overall, we believe it is good legislation, which will serve the people of Manitoba well. That said, we think it would be further enhanced with these few improvements. On behalf of the 12,000 plus registered nurses, nurse practitioners and graduate nurses, I thank you for this opportunity to make these remarks.

Madam Chairperson: Thank you very much, Ms. Doerksen.

***** (19:10)

Ms. Oswald: Yes, thank you very much, Ms. Doerksen, for a very well articulated and concise brief today that will help inform us as we go forward. I want to say thank you to you and all those at the College of Registered Nurses of Manitoba for the incredible amount of work that you've done to support this legislation going forward. Most of the people in this room are aware of the hours and hours that have gone into this, but maybe some day in *Hansard* it will be read by others that do not. All the professions are to be commended for how much energy you've put into this bill. So I thank you very much.

Madam Chairperson: Thank you.

Mr. Gerrard: Just a comment on the advisory council's membership *[inaudible]* prohibiting a member who regulated health professions from being part of the council. It should be removed.

I suspect you would be comfortable if there was, you know, a limit on the proportion of the members of the council who represented regulated health professions. I mean, it's just like, you know, your council, you would like it to be half and half, that there would be some reason for saying, well, we'll have a representation from the regulated health professions, but there must be a significant number who are not necessarily from those professions.

Ms. Doerksen: Yes, our experience has been having one-third public representatives on our board has served us very well and enhanced many of our discussions. And something similar to that, having a regulated presence on that advisory council would also, I think, enhance those discussions.

Mrs. Driedger: Thank you, Ms. Doerksen, for your presentation.

I have a question in terms of the appointment of public representatives, and you had indicated that currently you have the ability to appoint half and with this legislation it is going to drop you down to one-third.

What kind of, I guess, discussion have you had in terms of why this change was made during the development of this legislation?

Ms. Doerksen: First of all, just to clarify, we do– there is one-third public representatives on our board, and we share the appointments of those with the government. So we appoint half; the government appoints half. So we have six public representatives, and we appoint three, and the government appoints three.

And I'm not certain. I don't know why that change has been suggested.

Mrs. Driedger: On the advisory council membership, is there a mechanism that could be in place when you've got 22 different professions out there?

Is there an easy mechanism for having representation from the regulatory bodies on an advisory council?

Ms. Doerksen: The regulators work very closely together, and I would suggest that we would ask the regulators to make a decision about that.

Madam Chairperson: Thank you very much, Ms. Doerksen.

Seeing no more questions, I thank you for your presentation tonight.

Next on my list, I have Dr. Sandy Mutchmor from the Manitoba Dental Association.

So you have copies available?

You may begin whenever you're ready, sir.

Mr. Sandy Mutchmor (Manitoba Dental Association): Good evening. My name is Dr. Sandy Mutchmor, and I am the current president of the Manitoba Dental Association.

Thank you for the opportunity to appear before the committee and comment on Bill 18.

As a regulator for dental and dental-assisting professions, the Manitoba Dental Association appreciates the recognition in the document of a regulator's role in improving access to care, continuing competence and access to justice.

A regulatory body cannot be distinct from its significant responsibilities that society places on a profession but must mirror those expectations in its function.

The MDA board's position is that what serves the best interests of the public serves the best interests of our profession. It places significant resources and efforts in these areas now. Statutory authority will further enhance our abilities to promote the public interest.

We have identified several issues in Bill 18 requiring clarification relevant to dentistry and dental assisting. I will focus on the following: designation of a health profession; definition of dental appliance dispensed, prescribed and prescription; and provision of fee guidelines.

Designation of health professions: From an outside perspective, the name of a regulatory body may seem to be a minor consequence. As president, I have concerns that drastic change may have a detrimental impact on continuity and regulatory functions, reputation and relationships with the public and membership.

The Manitoba Dental Association has had statutory responsibility to regulate dentistry in the

province for 125 years. Unlike many provinces, an organization advocating for the interests of dentists has never evolved in Manitoba. A small profession, limited volunteer base, high administrative costs and member disinterest in lobbying may be some of the reasons a professional interests association does not exist. Manitoba dentists generally view aggressive marketing and government lobbying as inappropriate for a profession.

The MDA does not advocate on behalf of individual members to either the government or other organizations. A communication–any communications with the government or its departments is focussed on public health issues including institutional dental care for seniors, dental programs administered by Employment and Income Assistance, improving recruitment and retention of dentists to rural and northern Manitoba with the Office of Rural and Northern Health, and discussions with the University of Manitoba Faculty of Dentistry on changes to admissions policies to improve the access to care for underserved Manitobans.

Although a rose by any other name may smell–may swell as–smell as sweet, it would take a significant marketing campaign to make the public aware of the name change. Similarly, changing the name of 125-year-old regulatory body would require a considerable public awareness program.

The MDA has made a consistent effort to raise awareness, improve public knowledge of our organization, its regulatory functions, oral health information and the peer review process. Those efforts will be lost if a significant name change occurs. Any change will have considerable conversion costs associated with changing everything from the name on the door to accessing the Web site. All letterhead, binders and manuals will have to be redone.

For continuity of regulatory functions, reduced public confusion, retention of well-established relationships and trust, inclusion of all regulated members, dentists and dental assistants, and recognition of the important and ongoing contribution the MDA has made to the regulation, both in the province and nationally, please consider the continuation of the name Manitoba Dental Association. If this is not possible, an alternate choice would be the College of Dentists of Manitoba as the new designation for the regulatory body of dentists and dental assistants.

Definition of dental appliance: The broad definition of dental appliance in the document may present an issue for safe regulation. Currently, denturists are interpreting the current limiting–limited wording of their statutory authorization–authorized activities to allow for design, fabrication and fitting of any removable dental appliance, including snoring and sneep–sleep apnea appliances, partial dentures with existing live teeth in the mouth and implant-retained dentures. The vast majority of these tasks are performed without prescription as anticipated by The Denturist Act.

Other jurisdec–jurisdictions–recognize denturists performing these activities pose a risk to public safety. Private expression of concern to their regulatory authority of their seemingly unilateral decision to expand the denturist scope of practice from dentures, as described in The Denturist Act, to dental appliance as an–and examinations–are politely disregarded. Denturists may be well aware of their act's requirements for an oral health certificate or a prescription, but many do not comply.

Definition of dispense, prescribe and prescription: The three definitions in section 3 have three interconnected issues. The definition of prescribe includes the authorization to dispense a dental appliance. The following definition of prescription is limited to a drug. For consistency and clarity, the MDA would suggest including in the definition of prescription, quote, (a) in respect of a dental appliance a direction to dispense the appliance as designed in the directions for the person named in the directions.

Provision to fee guidelines: For the reasons previously described, the MDA is the only provincial dental organization. One of the tasks the MDA undertakes is to annually develop and release a fee guide. The fee guides are non-binding and intended to provide information and descriptions to the public, dentists, third-party payers and the government to aid in the decision-making process. The objectives in developing the guide is, is the fees are fair and reasonable reflecting the time and intensity, degree of skill, risk, judgment, stress of providing the services.

The MDA requests subsection 10, 3 be modified to allow a dental regulatory body to continue to produce a voluntary, non-binding fee list. The MDA position is based on the benefits the public receives from the production of a fee list. The public interest benefits are: increased transparency; complexity of

factors necessary to consider in establishing a fee list; public demand and expectation for the service; improved patient access to information; accountability to the public through bro–through board approval process ensures the best practices in the development, which has a pro–competitive effect; and improved productivity by reducing individual practice and third-party payer administrative burdens that can be passed on into the patients.

***** (19:20)

Increased transparency: A fee guide facilitates direct comparisons of prices by the public and government agencies, not only between different dentists, but also between general practitioners and specialists. These direct comparisons can occur between any region in a province and even interprovincially, except with Québec. Without the fee guide, patients would need to place significant effort into understanding the services being offered, the coverage provided and the comparative value. Fee transparency would be dramatically reduced. The result in inefficiency cost to insurers and dental offices would ultimately be passed to the patient.

Complexity of factors: Every dental fee guide, including those produced by the MDA, contains a myriad of fees which are defined in technical terms to properly describe and differentiate complex services. The guide is used by all third-party players for claim submission, processing and payment. In addition, the recommendations for the fee list are based on a di–a detailed review of the prova–provinces' economic conditions by an independent economic analyst. The factors include the forecasted increases in employee wages of the dental offices, other practice cost, inflation forecast measured by the CPI, forecasts of base private-sector wage and salary increases for Manitobans in the coming year, union settlements and other economic conditions.

Within the fee guide, comparative value between the individual dental services was originally established through comprehensive time-skill level studies analogous to those used for medical fees. Relatively, relativity assessment is reviewed as changes in technologies and practices occur. These complex reviews would be difficult for an individual dental practice to perform.

Public demand and expectation for the service and improved patient access to information: While appreciating the potential risks of a voluntary nonbinding fee guide for a profession, when it comes to a health care, the public prefers the–and expects predictability and consistency in the costs of health-care services. At the very least, they need a baseline information to assess the reasonableness of the service costs. The MBC–the MDA receives many complaints about dentists charging different fees from the fee guide. We have never received a complaint about dentists basing their services on the fee guide. Similarly, members of the public are usually surprised when they realize dentists have no obligation to follow the guide.

These opinions are mired in news articles on the issue. Asymmetric information and patient vulnerability require a high degree of trust between an doctor and patient. Once the necessary trust relationship is established, patients are very reluctant to change health-care providers, seek second opinions or alternative fee quotes. Additionally, in dentistry, the opportunity costs of acquiring alternative fee quotes usually outweigh any benefit which may be gained. The benefit of having a responsible regulator produce a fee guide is it gives the public a cost-free method of assessing the reasonableness of the cost quoted for their treatment, or it allows–

Madam Chairperson: Sorry, I, I just want to let you know you have 30 seconds remaining.

Mr. Mutchmor: Well, I'll keep going as fast as I can.

The system used to establish an MDA fee guide must comply with those board's primary consideration of public interest to meet those expectations. The MDA relies on best practices criteria of the Competition Bureau of Canada, the United States Department of Justice's statement on antitrust enforcement in health care.

Briefly, the process consists of an independent and economic analys–analyst contracted by the MDA recommends the annual adjustments to each guide. An economic committee reviews these recommendations, and the board, composed of members, dental assistants and public representatives appoted–appointed by the government, receives and reviews the recommendations for acceptance, rejection or modification.

Madam Chairperson: That's, that's your time, sir. Thank you very much.

Ms. Marilyn Brick (St. Norbert): I just wondered if we could have the presentation as provided to us in the written format appear in *Hansard* as read.

Madam Chairperson: Is that agreed by the committee that the presentation will appear in *Hansard* as written? Agreed?

Some Honourable Members: Agreed.

Madam Chairperson: Agreed. Questions.

Ms. Oswald: Madam Chair, not a question, just a comment. Thank you for your comprehensive brief on a number of issues that will help inform us as we go forward. I really thank you for being here tonight.

Madam Chairperson: Any other questions? Seeing none, thank you very much for your presen–oh, Dr. Gerrard, sorry.

Mr. Gerrard: Just quickly, because I think that the question will come up and it's probably better to ask it. The–your sense is that having a fee guide, that there is no conflict of interest doing this and being a regulator at the same time?

Mr. Mutchmor: Because of the, the process that I, I didn't really get to completely go into, about the way we develop that, we believe that it's, it's something that does not–it takes out any competition or anything like that. It allows–it's based on very sound principles and so on. It's got the input from the appointed representatives that sit on our board and some of the lay people, so we believe that that keeps it transparent. And it's something that's become a valuable tool for government and so on to use in terms of figuring out fees that are paid for things like social allowance and FNIHB and many others. For organizations that–to try and bargain this individually with 400 dental offices in the province would create a huge burden.

Madam Chairperson: Thank you, Dr. Mutchmor. Thank you for your presentation.

Next on my list I have George Fraser from the Massage Therapy Association of Manitoba.

Welcome, Mr. Fraser. We'll take the copies of your presentation. You can begin whenever you're ready, sir.

Mr. George Fraser (Massage Therapy Association of Manitoba): Thank you, Madam Chairman, Madam Minister, and members of the committee.

My name is George Fraser. I'm executive director of the Massage Therapy Association of Manitoba, and our association represents about 85 percent of the professional massage therapists who practise in the province.

The board of directors of the association has reviewed the document titled "Proposed Umbrella Health Professions Legislation: The Regulated Health Professions Act" of January of 2009, which became Bill 18 and which is being reviewed by the committee.

The MTAM has also been involved in and followed the Province's, and I have the word "slow" here, progression towards this important event. We have been outside the regulatory tent and have not been at the same high level of consultation as those inside the tent have been.

In 1994, the Law Reform Commission released a comprehensive report and recommendations concerning regulating professions and occupations, and this report has been used widely in Canada and other countries as a reference document for all issues relating to regulation.

Over five years ago, and you have correspondence in front of you of our journey with respect to regulation going back to 1973, but in October, October 15 of 2003, the then-Minister of Health and his department indicated they were seriously considering the introduction of a health professions umbrella legislation package. The minister also indicated at that time, as such, it is unlikely that we would be bringing any new regulatory legislation for an unregulated health profession within the next few years. This is including a moratorium on application, and that has been the case for the profession of massage therapy.

Massage therapy is regulated in three provinces at present: Newfoundland and Labrador, Ontario and British Columbia. The Minister of Health of Alberta has recently announced, following public hearings, that the profession of massage therapy in that province will be regulated in the near future under its health professions act. New Brunswick and Saskatchewan are in the application process.

Page 2 has–puts in a little bit of perspective of the number of massage therapists in this country and in allied professions, those that massage therapists work most closely with. There are 500 naturopaths, 580 homeopaths, 2,800 acupuncturists, 5,900 chiropractors, 9,000 physiotherapists, and 20,000–plus massage therapists of which 62 percent are regulated.

The Province of Manitoba does not recognize massage therapy as a health profession at this point, as I indicated, indicated, and, subsequently, the

profession is not recognized by Workers Compensation or the Manitoba Public Insurance Corporation. Massage therapy treatments are not eligible for income tax deductibility by Manitobans under The Income Tax Act for the same reason. In addition, massage therapy still attracts GST, again, for the same reason. These items will be discussed in more detail upon application by the profession for status within the new act before the committee, and we're looking forward to that.

***** (19:30)

Our main purpose today is to provide some comments on the new act. First area I'd like to move to is interpretation under definitions. Terms like risk of harm, public harm, and public interest are used in most HPA documents found in Canada. The terms are either undefined by legislation or are defined later by way of regulation. It is the opinion of the MTAM that it would be additionally progressive for the Province of Manitoba to add definitions of the– these key phrases when this is im–within this important section of the act, the interpretation section. This would assist the public in understanding the terminology used and, consequently, the purpose of the act.

One example of such a definition comes from part 3, public interest criteria of the British Columbia regulations under their HPA, which broadens the traditional definition of risk of harm or public harm by stating the following: The minister must consider the extent to which the practice of a health profession may involve a risk of physical, mental or emotional harm to the health, safety or well-being of the public.

Our association supports this approach to definition in principle as it captures the reality within which most regulated health professions functor–function under legislation. It embodies the common areas of complaint received from the public without restricting the reference to only physical harm. Such a definition helps the public understand what is meant by public interest and public harm. At the–at minimum, a definition of this nature should be included in part 1 of the interpretation.

In addition, the British Columbia HPA, under part 3, inspections, inquiries and discipline, contains definitions of professional misconduct, which includes sexual misconduct, unethical conduct, infamous conduct unbecoming a member of the health profession, and also defines unprofessional misconduct. These are terms often found in registered complaints against health professionals. These references are worthy of being included in that definition section.

The Ontario HPA creates a zero-tolerance approach to sexual abuse of a patient and defines clearly what is meant in that regard. The Province of Manitoba should consider a similar clear definition of its intent in this public-harm area. Citizens of Manitoba also have a strong opinion on zero tolerance regarding sexual misconduct and the MTAM is certain they would welcome this reference and definition. In addition, Ontario directs health professionals with knowledge of sexual abuse of patients that they have a duty to report, particularly sexual abuse and sexual misconduct.

Under the reserved acts process, the only comments that we would like to make in this respect is there's growing use of acupuncture practised amongst our members and members of other health professions, and, at present, the HPA here in Manitoba does not address that, and it should. Other reserved act areas drawing attention in other provinces include traditional Chinese medicine, which is emerging within the Manitoba population, and it, too, should be addressed as it is in Ontario and British Columbia.

The MTAM also observes that its members are becoming more and more active in the use of modern electro modalities such as low intensity laser, ultrasound and TENS muscle stimulators for soft-tissue treatment, and are experimenting with other forms of auxiliary electro treatments, including sho–shock treatment devices. Since these devices are commonly found in the market, they should be addressed within the reserved act process at the time of the drafting of that–we felt it should have been, at the time of the drafting of the new act.

The last area we'd like to address in what is a short time frame, always, in these types of presentations is part 11, new regulated health professions costs. And, again, we're focussed on application. Our association recognizes that the act builds in partial cost recovery concepts from those making application for regulation. However, the MTAM favours a limiting clause being added, which is found in the B.C. Health Professions Act. And I've listed it below and it–in part b, it says, limits on the minister's authority to charge costs upon–under section 9 of their act, so there's a ceiling on the cost process. This act doesn't have that. This does not leave an open-ended ceiling for costs that could

become, become prohibitive for the applicant. Most often, the applicant is a not-for-profit association with limited resources in that regard. Escalation of the costs could be out of the applicant's control, depending on the amount of investigation and administrative support required by the advisory council or the minister, minister's office by a single application. Cost should not be a deterrent to application, and total costs should be known at the time of application.

We'd just like to end by again thanking the staff from the department for answering my call–my frequent calls in respect to the act. I, I didn't want to diminish the complexity of this whole process, but from our perspective it's been a, a long time. And our association, our members across the country, of course, have been working under an HPA format in Ontario, Alberta and British Columbia for a number of years and we look forward to an opportunity to do that here in this province. Thank you.

Madam Chairperson: Thank you very much, Mr. Fraser.

Ms. Oswald: Yes, thank you, Mr. Fraser. I want to commend you for bringing the weather along with you to add to the gravitas of the message you're sending tonight, and you have been sending for lo these many years. I appreciate the detail that you provided in your brief. There are a couple of interesting points in here after all of our discussion I had not yet considered, and so I, I'm very pleased that you brought them forward and again I commend you for your advocacy and for your good counsel as we go forward.

Floor Comment: Thank you.

Mr. Gerrard: Yeah, you've been going a long while without having had the recognition which you got in other provinces.

My comment actually is with regard to the, the devices that you put in here, low intensity laser ultrasound, tense muscle stimulators, et cetera. Is it actually necessary to put all devices–I mean, I'm sure that there are a lot of and varied devices which are not necessarily mentioned in the act which, in some fashion or another, would be included. Isn't there a more generic way that can be covered here rather than listing every device that might be applicable?

Mr. Fraser: Perhaps there is, but as Canadians it's one of the weaknesses within our system. These devices often are unregulated in, in the truest sense from manufacturer through to, to use, and I guess our particular concern, and I'm sure concerns of other professionals here, is that untrained individuals can operate them. They can purchase them in the marketplace and operate them, and I think that's the biggest weakness. And so this may be stop gap to include this within a, within an act or within a, a health professions section of an act, and it may be better addressed, you could be absolutely correct, in a different manner. But, at present, there's no addressing of this, and it's something that needs to be addressed and that's perhaps our main concern from this standpoint. And, again, I don't think we're alone in, in this respect.

Mrs. Driedger: Thank you, Mr. Fraser. There's a, a part of this, of your comments that are very, very noteworthy, and with Ontario looking at a zero tolerance in its approach to sexual abuse of a patient, my question relates to whether or not it is just sexual abuse that is addressed or any other types of abuse, or does it zero in just specifically on sexual abuse?

I know that from the protection of persons in care legislation that we have and the report that comes out of that office, actually there is an astounding number of, of patients in hospitals and personal care homes over the last number of years that have been sexually abused and, I guess, one just never, you know, realizes how, how easily that can happen. So, when Ontario was looking at this, did they specifically just zero in on, on sexual abuse of a patient, and what has been the result of them including that in their legislation? Has there been, you know, more exposure or better ability to man–manage it or prevent it over the years?

***** (19:40)

Mr. Fraser: Well, I believe the, the zeroing in on, on zero tolerance certainly drew awareness in all professions, and it drew the attention of all regulatory colleges, including the College of Massage Therapists. And the College of Massage Therapists publishes on their Web site, have for many, many years in Ontario, published the various decisions that they've made under, under a discipline process. And, in the early stages, you'll see a number of complaints with respect to sexual abuse by practitioners, by professionals, and my observations would be that, in the latter years, that has been reduced substantially.

So it was a very strong message, I believe, that went, in a legislated format, to everyone and has helped in the general process of awareness amongst

all professionals that, if it happens, there will be no tolerance.

Madam Chairperson: Thank you, Mr. Fraser.

Seeing no other questions, I thank you for your presentation.

We'll move to Randall Stephanchew from the Manitoba Pharmaceutical Association.

You can begin whenever you're ready.

Mr. Randall Stephanchew (Manitoba Pharmaceutical Association): Madam Chair, Minister Oswald, members of the committee, I thank you for this opportunity.

My name is Randall Stephanchew. I am the president of the Manitoba Pharmaceutical Association. Joining me here this evening is our registrar, Mr. Ronald Guse and some members of MPhA council.

On behalf of the council of the Manitoba Pharmaceutical Association, I am very pleased to speak in favour of the overall concept of Bill 18, The Regulated Health Professions Act. However, I must strongly express our opposition to a clear exception made for the regulation and governance of the pharmacists in Manitoba as currently described in part 15.

In the very late stages of the development of this bill, MPhA was advised that the governance structure for the profession of pharmacy would be vastly different from all other professions included in the umbrella legislation. The exception made under part 15 was done without consultation with MPhA council and does not support the notion of consistency in governance in placing the public's interest first.

The process to govern the profession of pharmacy would leave the members to determine and approve the content regulations, the standards of practice and rules for continuing competency, and the members would have final approval authority of the contents of the code of ethics. The members', the members' authority will override that of the council of the College of Pharmacy, a body who will swear an oath to put the interests of the public first. This distinction will allow pharmacists the ability to place their own interests above those of the public. Although mostly pharmacists are very fair and judicial in their perspective, the separation of the profession poses the basic and primary reasons for this legislation. It represents a serious issue that must be corrected through amendments to the bill, to this bill, prior to third reading in the Legislature.

As the committee will note, the description of the mandate of all colleges and their respective councils is to govern its members in a manner that serves and protects the public interest. With this exception made for the practice of pharmacy, it places the members in position to govern the council and the governance of the college of pharmacists will be unique among all the regulated health professions in Manitoba and among eight other provinces in Canada. The council is hopeful this could not have been government's intention when creating this bill.

The MPhA was one of the first licensing and regulatory bodies in the province to have public representatives appointed to the council. Under this bill, as it stands, the proportion of public representatives will be increased to one-third of the governing council. We wholeheartedly support and welcome this change as we have valued the role of public representatives.

However, this increase in the valued role of the public will be undermined as the council for the college of pharmacists will not have the authority to make the final decision on regulations, standards of practice or continuing competence. The decisions for these documents will be left to the members. In addition, all other health professions in Manitoba will have their governing councils decide upon the code of ethics, but pharmacy will be required to have the members approve the code of ethics.

The committee also should be aware that this marginalization of pharmacy was done without consultation with the council of MPhA. When council became aware of this, a motion was passed at the April 17th, 2009, council meeting that states: Council does not support the exception being applied to pharmacy with respect to council's autonomy in the regulatory process on the grounds that the exception is inconsistent with the objective of the health professions act and detracts from the role in protecting public health.

It is important to note that Mr. Bill Regehr, a ministerial appointment as a public representative on the council of MPhA, seconded this motion.

The MPhA was first constituted through provincial legislation in February 1878 and has been licensed–has been the licensing and regulatory body for the practice of pharmacy in Manitoba for 131

years, with a strong record of public protection and patient-care initiatives in the province.

Bill 18 has been developed through widespread consultation with stakeholders and the 22 health professions in Manitoba. This legislation is an important follow-up to a Law Reform Commission report issued in the 1990s, which was a timely report identifying the need for legislative consistency in health-care professions' legislation. The consideration of feedback provided by the MPhA during the development of The Regulated Health Professions Act was recognized by representatives of Manitoba Health, as adding value to the legislation which was presented in the Legislature on April 16th, 2009. MPhA council was disheartened by the departure from this consultative approach at the eleventh hour, which resulted in this anomalous treatment of pharmacy in the bill before you.

The committee may hear that pharmacists presently have the right to vote for regulations under the current act and passed but yet to be proclaimed December 2006 Pharmaceutical Act. This is a somewhat recent phenomenon back in December 1992, and the first tabled version of the December 2006 Pharmaceutical Act did not continue the pharmacists' right to vote for regulations.

This was a very late amendment done in the Legislature. Although the protests of some of the pharmacists and some of their advocacy groups are well meaning and understandable, the governance in public interests principles contained in the bill must prevail. We urge you to right this wrong and correct part 15 of the bill to reinstate the consistent approach to regulation which was put forth as the primary reason for moving to umbrella legislation.

As the minister stated on introduction of the bill, and I quote from *Hansard*: "We believe this harmonized approach to health professions' governance will be a strong step forward for Manitoba patients and Manitoba people."

MPhA does have a second issue we wish to raise to the committee, and you've also heard it earlier tonight. In part 10, section 145 excludes members of a college of a regulated health profession or its council from being on the advisory council to the minister. The committee should reconsider this section. Having a limited number of members of a college or a college's council on the ministerial advisory council would enhance the ability of their council and their roles to provide advice on the items listed in part 10. It is unclear why these highly trained, experienced and knowledgeable individuals would not be, at the very least, eligible for appointment to the advisory council.

In closing, the April 16th press release of the Minister of Health (Ms. Oswald) regarding introduction of this bill stated, and I quote: The updated modern legislation would ensure all health professions in Manitoba are governed by consistent, uniform regulations with the enhanced focus on patient safety and accountability.

We are hoping the committee will hold the minister to this commitment and amend the legislation by removing sections 210, 211(1) and 211(3) from the bill, and also amending the language in section 145 to allow for members and council members to be eligible for the advisory committee.

The Regulated Health Professions Act is a very strong legislation for the continuance of the self-regulation of the health professions under solid governance principles, but also very clear legislation for the provision of care by competent professionals ensuring protection of the public interests. Both of these concepts are fully supported by the pharmacy profession, and we look forward to being a full participant and contributor through consistent and uniform legislation.

Thank you very much.

Madam Chairperson: Thank you, Mr. Stephanchew.

Ms. Oswald: Well, thank you, and now we've heard both sides, one earlier this evening and certainly one from your organization. We know, of course, that pharmacy and pharmacists have been on a journey for some time now, and I commend you on progress that has been made since Bill 41 was passed. We're not all the way there yet, and I concur with your statement that the legislation was amended at that time and unanimously supported in the Legislature, which has a great deal to do with why the legislation appeared as it did.

My question for you–of course, you have not been president of the MPhA for a long time, but you have been a practising professional for some time. I'm interested to know if you can explain, you know, in whatever brief moments that you have, why there exists such an acrimony in the profession. Certainly, we know that probably not every doctor in Manitoba gets along, I'm guessing; not even every nurse, although they're a loving group. I'm wondering why, why do you believe that there exists at this time the

acrimony within the profession that has caused a, a delay in, in being able to come forward with recommendations on which the profession can agree. Why do you think that is?

***** (19:50)

Mr. Stephanchew: It's a great question. It's a difficult question for me to answer. I have been president since April of last year, of 2008, so just over a year now. The divisiveness in pharmacy, I'm not certain exactly why that exists. I do know that there's different scopes of practice. I do know that pharmacy for some is a business. Some others aren't in the business of pharmacy; it comes down to continued care for the patients, and, again, there's some differences of opinion on how we get that right. I know there's been a lot of great work done by previous councils in regards to trying to deal with these differences and these issues. However, I'm not certain why, but right now it appears that those regulations that have been put forward and drafted just don't seem to meet everyone's needs, and I think that's causing some of the problem. And also the mandate of MPhA is protection of the public versus some of the advocacy groups that are there to, you know, for the pharmacist per se. So I, I do think that some of these differences and challenges are playing into it.

Ms. Oswald: Thank you, and I appreciate–it's not my intent to ask you a crabby question and put you on the spot, but, but it's a complicated issue to be sure. Indeed, doctors have the occasional cross word with one another about scope of practice and, and nurses and, and other professions. It's just human nature I, I suppose, and I know that, that you will hear the other side say, how, how can, how can you suggest that, that we do not have the protection of the public at, at our heart's core, and that only your side has that. And, and for me that's been a, a difficult and complex issue to, to wrestle with, and, and I wondered if you had some insights on, on how you might respond to, to another side saying, we care about patients just as much as you do.

Mr. Stephanchew: I couldn't disagree with you in regards to that, about protection of the public and the government being committed to that. We see that day in and day out in regards to the great job that you do.

I just think with the regulatory body having been in that business and dealing near and dear with the pharmacies and licensing the pharmacists and the practice sites, sometimes I just think that we're on the front line and we're the ones dealing with these matters, so I think that's where the difference is. It's not saying that you would not be looking at protection of the public, it just comes down to we're more on the front lines dealing with those members.

Ms. Oswald: And just to clarify, I didn't mean me or government; I meant those individuals on the opposite side of the issue, who are members of the pharmacy profession.

Last point: Certainly, there's, there's requests in your brief and in discussions that have been going on, to be, to be treated like all of the other professions. And, and I want to say on the record that we're open to that, whether it's immediately or in the not-too-distant future, when some of the, the issues that I've talked about within the profession of pharmacy are, are resolved in ways that maybe more closely resemble the other professions.

There is a unique situation in the context of pharmacy, though, where there's not only governance of the members, but licensure of, of businesses, and that is, indeed, in and of itself, different. So it would beg the question, then, that, you know, on the one hand it's okay to be treated differently, and yet, as presented in your brief, it's not okay to be treated differently. I wondered if you wanted to comment on that, just briefly.

Mr. Stephanchew: Right now, the way that council has looked at this is they understand that other health professions do have some business components in there and they do understand that certain exceptions have not been granted to them. They just feel that for a council to be able to govern properly is that they have to have the same tools that everyone else and to work collaboratively with the other health professions. So I think that's where the focus and the decision of council came, and, again, I am the representative of council, to come here to tell you in regards to how they base that decision, but it was based on collaboration with the other health professionals, to be able to move regulations forward, not to hold up the process, and to be able to work in concert with everyone. So I think that was the mindset, when it was looking at being treated the same as everyone else.

Mrs. Driedger: Thank you, Mr. Stephanchew. There has been disagreement amongst the pharmacists for some time now. In fact, it's probably been going on several years, and there seems to be, you know, everybody sort of wants to reach the end point where you can agree on regulation, and it hasn't happened and it hasn't happened for a lot of years now.

Two questions: Should a consultant and/or mediator been brought in sooner by the government to help deal with this situation rather than only recently having that done? And were you surprised that this bill was brought forward before the PricewaterhouseCoopers report was completed?

Mr. Stephanchew: Well, legislative process is going to con–continue regardless of the activity that we're working on. It would have been, yeah, ideal if we could have worked with the consulting process that we're going through with PricewaterhouseCoopers right now to try to build consensus amongst the membership on many important issues. Regulation development is one of them.

In regards to speculating on whether that may have helped with the hearing tonight and if we could have met sooner, things progress very quickly. And again, we always heard that the umbrella piece of legislation was coming forward. Again, it's great to have that piece of legislation here right now. It would have been ideal if we could have, yes, had some of the stakeholders get together under a facilitated session to see if we were all in agreement and to have that consensus or the cohesive answer that one needs in order to whole-heartedly support legislation coming forward. But we have had discussions. There still seems to be some differences in regards to that, and as I've heard tonight, as there are some differences of opinion and approaches here, you will hear both sides and I trust that you, the committee, will make the right choice for pharmacy and for this act going forward.

Madam Chairperson: Thank you. The time for questions has expired. Thank you for your presentation.

Next I'll call, Kyle MacNair, Canadian Society of Hospital Pharmacists. You can begin whenever you're ready Mr. MacNair.

Mr. Kyle MacNair (Canadian Society of Hospital Pharmacists): Madam Chair, members of the committee and everyone in attendance, thank you for the opportunity to speak to this important legislation.

The Manitoba branch of the Canadian Society of Hospital Pharmacists is a voluntary organization of 180 pharmacists committed to the advancement of safe, patient-centred, pharmacy practice in Manitoba's hospitals and related health-care settings.

My name is Kyle MacNair. I'm the past president of the society. I'll be making this presentation on behalf of our organization.

I want to start by providing some relevant quotes and excerpts from materials regarding this legislation. I'm going to start with *Hansard's* Thursday, April 16, 2009, Minister Oswald. "Bill 18 will strengthen and modernize the governance, accountability and transparency of health professions and will enhance patient safety and consumer protection. Through extensive consultation and the co-operation of existing professions, we believe the harmonized approach to health professions' governance will be a strong step forward for Manitoba patients and Manitoba people."

The next five submissions are from the regulated professions–or, sorry, the health professions regulatory reform consultation document. This was submitted to all the health professions that were going to under this act in January of 2009. The first–there will be 21 different acts that regulate 22 health professions. We believe that the pro–proposed legislation will provide consistency in the power and duties that the government delegate to regulatory bodies, sorry, duties that the government delegate to regulatory bodies while strengthening patient safety, transparency and accountability to the public.

It's noted that many jurisdictions require public representation at all stages of the health professions regulations process. This provides a safeguard so that the concerns of the profession do not outweigh public interest.

Legislation for each health profession has the same purpose: to protect the public. However, they are not consistent with one another on how they achieve this public protection. Pursuant to that, the proposed legislative framework includes one umbrella statute with consistent legislative provisions for governance, registration, complaints, discipline, appeals, public representation, regulations and by-laws making which apply to all regulated health professions.

I think–sorry, and the last point, the umbrella legislation will establish a clear mandate for all health profession regulatory bodies to be known as colleges to protect the public interest and separate professional advocacy from regulatory activities.

***** (20:00)

I think the last point is very important. It elucidates the fact that each health discipline needs to be elec–has an elected body who will give up countless hours of their time, who become informed on all issues that face the profession, who will take

an oath to protect the public, who will work with the public representatives on their council to regulate the health discipline. And they shall do so free of influence from the profession's advocacy.

These quotes are generally true of Bill 18. It does do all these things. It is a step forward for many ways to help disciplines in Manitoba, except for pharmacy. The following exceptions are made for pharmacy discip–for the pharmacy discipline: 210, beyond the practice of passing the regulations and standards of practice by the government, they will include a vote by the members; and 211(1), 211(3), where the code of ethics will be under the same rules.

What these exceptions accomplish are to remove the harmonized approach to health professions governance; to provide inconsistency in the powers and duties that the government delegates to the regulatory bodies; ensures the concerns of the pro–of the profession can outweigh the public interest; removes consistent legislative provisions for governance and regulations; and, finally, it does establish a clear mandate for pharmacy regulatory body to protect the public interest, but it does not separate professional advocacy from regulatory activities. In fact, it firmly cements the power of the profession's advocacy body to influence and even veto the regulatory authority of the college.

Why has this exception been made? In the words of the assistant deputy minister in correspondence with the pharmaceutical association, the unique role of the college of pharmacists in regulating commercial practices is one of the reasons that the MPhA has a specific requirement for membership approval of regulations. I find this notable and disturbing in two ways. Government rightly recognizes that many pharmacists currently practise in highly commercial settings. They recognize the business interests may not always conform with the best interests of the public, and they've chosen to put commercial interests ahead of public interests through this legislation. Second, as a hospital pharmacist, this ignores the significant and growing component of the pharmacy profession at work in non-commercial environments. The regulation, the regulation of our important role will be subject to the decision making of a majority of pharmacists who may not appreciate our unique environments and our professional needs.

The other pharmacy advocacy organizations in the province really only describe one defence of the pharmacists retaining the right to vote which basically states: We currently have the right and pharmacists want to retain the right.

I submit to you two considerations. First, not all pharmacists have this sentiment. Many believe we should be regulated the same as other health-care professions, and both the mandate and authority of regulating the professions need to be held within an objective body, i.e., the college. Second, wishes of the pharmacy community are not the only consideration this government should have; in fact, it shouldn't even be the most important consideration. This government is passing legislation for the protection of the public, not the interests of pharmacists.

The weeks leading up to this session have been challenging. There's no question our profession has some serious divisions within it; this debate of the right to vote would cause any profession to have these. The government is aware that the pharmacy profession is currently working through regulations for The Pharmaceutical Act of December 2006 known as Bill 41. This legislation will not be proclaimed until regulations are approved by the pharmacists who, under Bill 41, have the final say before referred to the government. We are told they have likely years before the Bill 18 actually comes into effect for pharmacy. So pharmacists are going to have the opportunity to vote on regulations for Bill 41.

Why, then, does Bill 18 single out pharmacy as an exception now? In the spirit of trying to provide constructive commentary, I'll leave you with the following two considerations. Surely, the government recognizes the inconsistencies that they are creating in these legislative exceptions and how they don't meet the mandate of the legislation. We feel the pharmacists must go through the process of building regulation development for both Bill 41 and Bill 18. Then a sunset date should be established within Bill 18 after which the exceptions being made for pharmacy on regulatory and code of ethics decisions making be removed– remove 210, 211(1) and 211(3).

Secondly, from the point of view of hospital pharmacists, there is a serious potential that the regulations born of members-driven process will be contrary–will contain many self-interest provisions and protectionist measures that may not be compatible with the evolution of hospital pharmacy practice. If this occurs, serious consideration will

have to be given to removal of hospital pharmacy from the bounds of pharmaceutical legislation. This is not the wish of the Manitoba branch of the Canadian Society of Hospital Pharmacists, and we will work to try avoiding it, but the possibility is nonetheless there.

In closing, I, you have an opportunity to rectify the direction this bill has taken and recognize pharmacists first and foremost as health-care professionals whose first responsibility is to the patients. In that end, we hope you choose not to abdicate your responsibility and weaken the altruistic goals of this bill to enshrine the protection of the public within all disciplines under the act, and to remove sections 210, 211(1) and 211(3) either now or in the near future. Thank you very much.

Madam Chairperson: Thank you, Mr. MacNair.

Ms. Oswald: Yes, thank you for your presentation. It's comprehensive and detailed. Of course, our government, you know, strongly supports the hospital pharmacists as, you know, evidenced by commitments that we've made to expand your role, and we will make good on doing that.

I'm just wondering about pharmacists that work in commercial environments. Are there any of them that put their patients first?

Mr. MacNair: Well, I mean, I'm certainly not going to suggest that that is not the case. They, I'm sure, do. I'm just saying that there is a moral hazard associated with potentially community, or commercial environments that may not easily allow the discerning of, of, of, of specific patient needs with the profession's needs.

Mr. Gerrard: Thank you for your presentation. Just, I mean, the, the, no, I think a number of us are struggling to understand, you know, the differing points of view in the pharmacists, and, maybe, to help clarify it, can you give us an example of, in the regulation, where, that you're discussing at the moment, problematic area where there might be a concern of public versus commercial interest? Can you give us an example of, from hospital pharmacy perspective, you know, where there would be something that would be distinctly different from a community or long-term care pharmacist?

Mr. MacNair: I guess I'll start with one rep–issue with the regulations that is concerning to pharmacy practice right now, and individuals from the WRHA are here. The WRHA is involved in a massive expansion of the pharmacy program, or changes to the pharmacy program such that technicians will be handling the primary dispensing duties within the, within the practice. The current proposed legislation, the current regulations that exist will remove our ability, or will restrict our ability to delegate certain functions to technicians. It's a–believed to be, we believe in it a protectionist measure and it'll affect hospital pharmacies' ability to advance and provide patient care on the wards and on the out-patient services and things like that. So that's one aspect that we're concerned about. And, sorry, the second question?

Mr. Gerrard: In terms of the, the hospital pharmacists, I mean, you, you've provided some concept, but, in having technicians there is, in provided that they're well supervised and that things are looked after well, there's not a public safety interest. In fact, I mean, one could argue that you have to be careful if you're going to have technicians doing things which are done by pharmacists, that that may or may not be better for public safety.

Mr. MacNair: I guess, I guess I'll speak briefly on the Blueprint for Pharmacy which indicates that technical roles in pharmacy practice should be conducted by technicians. They do a better job of it. They provide better checking processes and more accuracy in that area. And the value of a pharmacist isn't in their ability to check and to provide a dispensing role; the value of the pharmacist is to improve drug therapy and improve drug-use management in the province is being out, away from the dispensing role in providing those key services outside. So I, I guess, from a public, from a, from a, from a point of view of best drug use and public safety in that way, I mean, the, the technician role is important.

Mrs. Driedger: Thank you, Mr. MacNair.

My questions to you are with the PricewaterhouseCoopers group that is looking at helping to move along this process. We certainly see that the factions within pharmacy have been really struggling to come together and agree on, on regulations, and that's been going on for quite some time now. Should a consultant medeor–mediator like Pricewaterhouse have been brought in sooner so that a report could have been finalized well before this legislation, you know, came before us so that we wouldn't be seeing the pharmacy professionals being torn apart by what is going on right now?

***** (20:10)

Mr. MacNair: I guess I will reserve the answer to that until I see what Pricewaterhouse produces. It remains to be seen what the–I mean, this Pricewaterhouse process has been going on since, I'm not sure, December, November, maybe, January. We've had three hours with them to state some of our concerns in that whole time, so we don't know what Pricewaterhouse is going to do and whether or not this process is actually going to result in any meaningful or a, a, a, a–we're hopeful it is, a meaningful consultation, or meaningful results, but, because we haven't been, I guess, in on the process, we don't know. But, and maybe if it results in a good outcome, yeah, we should of had it a long time ago. If it doesn't, well, who knows, then. They are certainly happy. They make a lot of money.

Madam Chairperson: Thank you, Mr. MacNair. That's all the time we have for questions. Thank you for your presentation.

Next, I'll call on Scott Ransome, from the Manitoba Society of Pharmacists.

You can start whenever you're ready, Mr. Ransome.

Mr. Scott Ransome (Manitoba Society of Pharmacists): Good evening. My name is Scott Ransome, and I am the executive director of the Manitoba Society of Pharmacists.

On behalf of the Manitoba Society of Pharmacists, I would like to thank the committee and the minister for the opportunity to present our views. It wasn't my intention to talk about, about the pharma–the, the, the importance that, that all pharmacists put on the safety of their clients. I, I just believe that that's an issue that can't be debated. So it wasn't my intention to even discuss it, but it has come up a couple of times tonight already, and it's objectional–it's certainly objectionable to hear.

By way of background, the Manitoba Society of Pharmacists was established in 1973, and is a not-for-profit voluntary organization whose purpose is to promote and advocate the economic and professional interests of its members. The membership is made up of mostly practising pharmacists and pharmacy students and currently has in excess of 1,000 members. The society wishes to lend its support to Bill 18 as currently written. Bill 18, as it has been presented to this Legislative Assembly, is progressive legislation which is consistent with the laws in other provinces which have already or, or are about to implement umbrella legislation for health professions. From a pharmacist's perspective, much of Bill 18 is virtually the same as Bill 41, The Pharmaceutical Act, which was passed unanimously in the Legislative Assembly on December 4th, 2006.

Regrettably, the Manitoba Society of Pharmacists, instead of using this time tonight to discuss the reasons for supporting Bill 18 in its current form, we must instead use this opportunity to discuss the importance of maintaining pharmacists' rights to approve changes to regulations and the code of ethics. I say that this is regrettable because less than 18 months ago, members of the Legislative Assembly considered this very issue. The decision at that time was that pharmacists should maintain their ability to vote on changes to regulations and the code of ethics.

You will recall, Dr. Jon Gerrard proposed amendments to preserve pharmacists' rights to vote, and these amendments were supported by all members in the Legislative Assembly. This decision of the Legislature has been very well received by Manitoba pharmacists, although, no doubt you will hear otherwise from a vocal minority over the next couple of days. The decision of the three parties to uphold this very important approval mechanism preserved a process which has been used successfully on many occasions since first introduced by the Honourable Don Orchard in 1991. It was the right decision in 1991; it was the right decision 18 months ago, and it is the right decision, as government recognizes, as of today.

How important are these voting rights to pharmacists? In March 2008, the Manitoba Pharmaceutical Association put forward a draft package of regulations to their membership, who are all licensed Manitoba pharmacists. And the members voted 66 percent in favour of not approving the regulations. You will hear from some that the defeat of this package of regulations is a reason for taking away members' ability to vote on regulation changes. I say to you, do not blame the process; blame should be directed to those who unnecessarily rushed a proc–process, provided limited real consultation and, with respect to certain sections of the regulations, absolutely no consultation. The right of members to approve regulations changes has worked successfully since 1991.

Another argument which will be advanced is why pharmacists should have the right to vote on regulation changes when other health professions do not have that same right. I tend to agree with

Dr. Gerrard, who suggests that maybe all health professions sould–should have similar rights. The right to approve regulations engages professions and educates them to the changes being considered.

It is also important to reference a couple of the differences between pharmacy and other health professions. MPhA's scope for regulation goes beyond that of other health regulators. The role of MPhA not only includes regulating the profession of pharmacy, it also includes licensing pharmacies and licensing and regulating more commercial and operation aspects of the profession.

One obvious benefit of maintaining their legal rights to vote on changes to regulations and the code of ethics is that the approval shields the government and opposition MLAs from unnecessary lobbying pressures. By requiring approval from the profession, Bill 18 assures that any changes to regulation or code of ethics before they're ever forwarded to the government of the day has the broad support of pharmacists.

Many of the presentations you hear over the next two evenings of committee hearings is from a very well-organized, vocal, small minority of the profession, many of whom work in public-funded hospitals, regional health authorities or the University of Manitoba. What should be asked is: who do you represent, have you consulted them and do you know they want their voting rights extinguished?

The Manitoba Society of Pharmacists has consulted our membership on this fundamental issue in order to bring forward tangible results to the members of this committee. A Probe Research study has been ongoing over the last four days. The results were received late this afternoon, and I enclose the following results in my presentation for you to review.

The results are as follows: When the question was asked, do you support or oppose pharmacists retaining the right to vote for or against regulatory changes affecting their profession, 93 percent respond they support retaining this right. When the question was asked, do you support or oppose pharmacists retaining the right to vote on the code of ethics, this time 94 percent indicated they support ret–retaining this right.

MPhA has not consulted with their membership, and they do not have a mandate to have their members lose their voting rights. The last time MPhA took this issue to the membership at a special general meeting was 2001, and the membership voted the suggestion down.

In addition to the results of the Probe survey, approximately 400 letters have been received by MSP members and pharmacists who are not members of MSP. These letters indicate support for MSP's efforts to maintain pharmacists' voting rights.

In closing, for the reasons given, the society supports Bill 18 in its current version and would not support any amendments which removes pharmacists' long-standing legal rights to vote. This model is not broken. We're in the process of developing innovative regulations. All pharmacy stakeholders are engaged in this Pricewaterhouse consultation process. We're only a few months away from bringing it to conclusion. Let pharmacists determine the future for the profession.

Thank you for the opportunity to present the Manitoba Pharmacists' Association's views to you today.

***** (20:20)

Madam Chairperson: Thank you very much, Mr. Ransome.

Ms. Oswald: Thank you, Mr. Ransome, for being here today and for providing a comprehensive and, indeed, passionate presentation to the committee tonight.

In the name of fairness, I must ask you a crabby question. On one side of this argument is the statement that pharmacy is being treated differently than all of the other professions, and I mean, this is not a false statement, and while, you know, I've put on the record as have others that because we recently went on this journey, as you pointed out, and had unanimous support for maintaining the voting rights of members, that resulted in government's decision to include pharmacy in the bill in that way.

But it is not an incorrect statement to say that pharmacy is being treated differently than the other professions, and I guess I would ask you, you know, why is that okay?

Mr. Ransome: I guess the question, you know, and what I don't understand is why other health professions over the years have been willing to give up the right to vote on regulation changes. We believe it's a very useful process. It engages the membership. It helps them an opportunity to come forward to make comments on the changes, to

improve the regulations, to make them better before they're even put to a vote.

I guess that could happen in a consultation process, but I think you just have a different level of engagement, and I guess the other thing is, for whatever reason, and maybe as the commercial aspects of the profession to some degree, pharmacy services are not insured services. They're out in the community. They're trying to keep their stores open. I guess they bring a greater passion to the profession in some respects. They want to be engaged. They want to know what's happening, and they want to have a voice.

Mr. Gerrard: Thank you, Scott. Just the right to vote goes back to 1991, and as you point out, there have been a whole series of positive results from that, and certainly the poll shows a lot of very strong support. Can you tell us a little bit about some of the positive results from earlier processes just to give people a feel for how well this has worked?

Mr. Ransome: I do wish I'd spent more time looking through some of the regulations that have been passed over the years. I guess, when I speak to positive results, I guess part of what I mean is that throughout that process, pharmacists, until this recent exception, always voted in favour of the regulations put forward by the MPhA council. In some respects, I really don't think that this struggle and what's gone on in the profession–I know it's easy to say that we're fragmented and that's currently the case, but it again is recent history. We're in the process of reforming our profession, and it is bringing passion to the table, and people want to have a voice. At the end of the day, the draft regulations that were defeated were a very large package, and in that entire package, there was only 13 regulations that pharmacists wanted further clarification on or felt needed to be changed. All the other regulations, parts of the regulations, generally were supported, certainly by the society.

Mr. Gerrard: Thank you.

Mrs. Driedger: Thank you, Mr. Ransome, for your presentation, and thank you also for being the one that told me about the PricewaterhouseCoopers company that was actually looking into this situation to try to help resolve some of the problems, and until you had mentioned it to me, I wasn't aware that that process had been put in place, and it sounded like it was put in place to help move this along to try to get the feedback from everybody, and, and try to help everybody come to a, a resolution. Certainly, in talking to all the various pharmacy groups, at the moment it, it certainly looks like the profession is being torn apart by, by divisiveness, but I'm glad to hear also you're saying that progress has been made.

Were you surprised actually that the legislation came forward when it did rather than waiting for the PricewaterhouseCoopers final report to have come forward? This seems to have jumped in front of that. It seems now like it's inflaming this process when you might have quietly all been able to work behind the scenes and get something done. Are you surprised that this legislation came forward then when it did before you had the chance–all of the groups in pharmacy–to actually, you know, have a chance maybe to resolve the issue?

Mr. Ransome: The timing was not ideal. The–it had–this, this issue has been a distraction and it's taken our attention away from the much more important issue, which is to get our regulations finalized, get them supported by all, all pharmacy stakeholders and taken to a vote, and actually get Bill 41 proclaimed finally. But, having said that, I think, as a profession, it might be selfish of us to think that the other 21 health professions that are also part of the umbrella legislation should have to wait just because, you know, we haven't quite got our act together yet.

Madam Chairperson: Thank you, Mr. Ransome. Time for questions has expired. Thank you for your presentation.

Next, I'd like to call on Troy Harwood-Jones of the Manitoba International Pharmacists Association.

You can start whenever you're ready, sir.

Mr. Troy Harwood-Jones (Manitoba International Pharmacists Association): Madam Chair, minister and members of the committee, thank you for allowing me to come before you and speak. The last time I spoke at committee was on Bill 41, and I'm here representing the Manitoba International Pharmacists Association or MIPA, as is our acronym. And I think that what–the benefit that I can bring to the committee is, is to provide an example of the relevance of the divisive issue which is, is sort of consuming everyone's attention right now.

The Manitoba International Pharmacists Association is a trade organization of licensed Manitoba pharmacists who provide international prescription service or IPS pharmacy care at a distance to individual residents, both outside and inside of Canada. The members of MIPA are pleased

that the voting rights of the members of the MPhA have been preserved under the, under Bill 18.

Although IPS pharmacies abide by all regulations and the code of ethics, the right of IPS pharmacists to practise has been rep–repeatedly challenged by the MPhA council over the years. Council has made several attempt to introduce new rules of practice that would prohibit IPS pharmacy in Manitoba. But for the requirements that council must receive a majority approval of their members for sudden changes to the regulations and code, IPS pharmacy would likely not exist in Manitoba today. And, over the years, MIPA has fought for the right of its members and all of the members of the MPhA to maintain their voting rights under the act despite a very clear message repeatedly given to council. The council of the MPhA appears intent on removing their members' right to vote.

And this–my intention is to briefly go over some of this history over the last eight years. This is particularly relevant to the IPS pharmacies and the journey they've gone on as they have been practising safely and within the regulations and the code. Now the act, the pharmacy act of Manitoba requires that provisions of regulations of the code must be approved by the members of the MPhA prior to being forwarded on to Lieu–Lieutenant-Governor-in-Council for approval. This is at section 71 of the existing act, and if you're following along you need to flip over to page 6. The, the reg–the regulation or the act reads, a regulation under subsection 71(1) does not come into force unleted–unless it is approved by the majority of the members of the association present and voting at a general meeting or voting by mail or other voting method. Incidentally, the voting method is relatively new and does provide for a speedy response.

***** (20:30)

Now, as I mentioned, there have been several attempts to change the rules, which have been a challenge for our IPS pharmacies. In 2001, the issue of changing the regulations without going to a vote, as you've heard, went to the members and, and the, the motions I've provided for you in the, in the presentation.

Here it is listed at the bottom of 6: Motion moved by Gary Cavanagh, seconded by Lois Cantin, that a change in section 71(2) of The Pharmaceutical Act take place to allow the elected council to put regulations forward for the protection of the public and that a proper policy would be put in place to allow proper consultation with the members. Defeated.

And a second motion with respect to by-laws was again introduced and clearly defeated.

Notwithstanding that clear message in 2001, at a subsequent meeting of the MPhA, the council, MPhA council on–in February of 2002, the council decided that they wanted to pursue regulatory amendments to the act without receiving the mandate from their members, and issued a newsletter indicating that they wa–were challenging the minister to change the rules of practice, that is, no licensed pharmacist shall sell a drug listed in schedule 1 of the manual except pursuant to a prescription and, when a patient is not resident in Manitoba–or Canada could be inserted–the prescription must be issued by a practitioner licensed in Manitoba.

This is a clear–I can say–attack upon our industry as we could not have complied with that.

This challenge was never agreed to by members of the MPhA and it would have put us out of business. It led to a controversy in 2002, including a petition, a meet–a special general meeting on May 14, 2002, and ultimately there–that firestorm of controversy, it forced the council to take a second look at their proposed action plan.

Also, in 2002, in October, the registrar of the MPhA, Mr. Ronald Guse, circulated a memorandum to pharmacy managers whereby he advised that the council had approved, in principle, changes to the pharmacy licence application requirements for those pharmacists practising in the province of Manitoba.

Once again, this is relevant to the story that I can provide to you with respect to the growth and the development of safe distance care pharmacy practice by IPS pharmacists in Manitoba. This memo and these changes, which were de facto regulations, would have, once again, put us out of business; again, a controversy in pharmacy.

Our members were forced to bring an application to try to make clear that the–these–the–that not only was this going to have a significant detrimental impact, but also that these were de facto regulations and not approved by the members.

Once again, due to all of that controversy, at the end of 2002, the members' right to vote on the regulations survived.

You have heard about 2006. That was the next time that the new pharmaceutical act, Bill 41, was introduced. In the draft, the voting rights had been re–removed. I understand that that draft was prepared by the consultation with the Pharmaceutical Association and a grass roots organization of pharmacists rose up, circulated petitions, compelled a special meeting and made it abundantly clear that they were very concerned by writing in letters to their MPs and to the government.

It's true that at that mis–meeting, Mr. Kyle MacNair, who you heard from tonight, introduced a motion which essentially introduced the pre-emptive motion which had the effect of cancelling the meeting.

You need to know that the pharmacist members were advised in advance of that meeting that the situation was that there was no opportunity to change Bill 41, and if they didn't agree to this–the Bill 41 in its entirety, that they had a chance of losing all the proposed changes in Bill 41.

So, there was, by a narrow majority at a very controversial meeting, the, the motion to cancel the–essentially, the all-or-nothing motion that had the effect of cancelling the meeting was passed.

Ultimately, of course, Dr. Jon Gerrard introduced amendments which we have heard about tonight with all-party support. All of the parties went on the record to say comments similar to that of Mrs. Bonnie Mitchelson: you know, I think, Mr. Speaker, we have a piece of legislation that is a little better than it was when it was originally introduced and that pharmacists will continue, as they historically have, to play a role in the governance of their profession. They will have an opportunity, as a rout–result of the amendments, to vote on proposed regulations, to vote on a code of ethics, which, I think, is important for them.

I have provided you with more information than this brief history of the controversy in pharmacy surrounding the members' determination to preserve their voting rights. I bring it to you because it's particularly relevant to the challenges faced by my members in demonstrating over the last eight years that they practice safely, ethically and within the regulations in the code. And notwithstanding the fact that they abide by all the rules of practice, they have been faced by repeated confrontations by a council that introduces de facto regulative changes and attempts to introduce changes to the requirements for their applications, which would have the net effect of putting our members out of business but for the check and balance of the pharmacist members, the broader pharmacist members of pharmacy in Manitoba, our–it is likely and, in my opinion, it is the case that the IPS community would not be here today.

Madam Chairperson: Thank you, Mr. Harwood-Jones.

Ms. Oswald: Thank you, Mr. Harwood-Jones. You paint an interesting historical picture here related to distance pharmacy and you reference on a number of occasions that your industry would not be here today for reasons that are quite compelling. Could you share with the committee today in Manitoba a few details about the industry? How many Internet pharmacists are there, distance pharmacists? How many employees do we have here in Manitoba and, and a little bit about the work that they're doing.

Mr. Harwood-Jones: Currently, there are approximately 750 with–to 1,000 people who are directly employed by IPS pharmacies in Manitoba. Their sales are approximately 400-million Canadian dollars annually. It is true that the number of IPS pharmacies in Manitoba has declined over the years through natural consolidation of the business and industry as it matures, and today, there are 14 IPS pharmacy licences that were issued for the 2009 licensing year.

Ms. Oswald: Just a quick follow-up. In the to-ing and fro-ing of this debate–again, on–you know, there are good points on both sides–there have been those that have implied over time that Internet pharmacy just isn't safe and I wondered if you wanted to have an opportunity to talk about that quickly.

Mr. Harwood-Jones: I would love to have an opportunity to speak to that.

I think our–it is–earlier tonight, we, we did hear a comment that business interests bring forth self-interested–and advocate and bring forth self-interested agenda items in order to advance their own personal interests. My members couldn't disagree with that more. Certainly, everybody has–should have–all pharmacists in Manitoba ha–should have the right to safe–of, to practise safely and within the rules and if there's a progressive form of pharmacy practice such as distance care pharmacy and IPS pharmacy, which takes advantage of new e-commerce opportunities for business marketing, that shou–should be something that the rules of practice can encourage so long, of course, as it is

safe. The rules, regulations and code and the protections that are provided by way of the pharmaceutical association are those things that the check–are the check and balance to ensure that it's safe practice. You have to practise within the rules and you're always subject to being inspected and being subject to a review of your peers.

What I can say to you and to this, to this committee is that over the last eight years, we have–our members have effectively, through the dispensing of millions of prescription orders safely, we have demonstrated that this is a safe and effective pharmacy model that can provide distance care delivery in a way that's not only safe, not only legal, but ethical and within the rules.

Mrs. Driedger: Thank you, Mr. Harwood-Jones. I think your presentation tonight certainly demonstrated again that the divisions within pharmacy have been going on for a number of years now. You've articulated, you know, year by year, some of the challenges that have been, been there and they obviously were issues that weren't resolving themselves. Should the government have brought PricewaterhouseCoopers in much sooner than what they did in order to help rectify this problem?

***** (20:40)

Mr. Harwood-Jones: My understanding is that the PricewaterhouseCoopers process is a process that was brought by the Pharmaceutical Association in conjunction with MSP. I understand that the government is very supportive of it, but this is an–to my understanding–it's an MPhA process, and if there were any delays in bringing forth the PricewaterhouseCoopers' process, those delays should be laid at the feet of the MPhA.

Mrs. Driedger: Can you tell me who's covering the cost of PricewaterhouseCoopers' analysis of what's going on, and, though, the work that they're trying to do to help resolve everybody sort of coming together and just, you know, coming to an agreement on regulations?

My understanding had been that the Minister of Health (Ms. Oswald) was the one that encouraged both those organizations to bring in PricewaterhouseCoopers, and I am wondering why that recommendation didn't come a lot sooner than it did, and I understand that it is government that is covering the cost.

Would you happen to know who is actually covering the cost?

Mr. Harwood-Jones: I don't know.

Madam Chairperson: Thank you very much. Time for questions has expired.

Moving on to Gayle Romanetz, or Romanetz. You can begin whenever you're ready.

Ms. Gayle Romanetz (Private Citizen): Good evening. My name is Gayle Romanetz, and I am a community pharmacist who has been licensed in Manitoba for 25 years. I also hold a dual licence in Ontario and I have practised there for 16 years. I am employed as a senior director of pharmacy for Loblaw Company, and I supervise the operations of 49 locations in Manitoba, Saskatchewan and Northwestern Ontario. My experience with the national employer has given me an opportunity to work with many health-care professionals in diverse retail and institutional practice settings, including nursing homes and correctional facilities.

I am appearing before you in support of sections 210 and 211 of Bill 18, sections that preserve pharmacists' longstanding voting rights.

The best way to predict the future is to create it. My personal vision for pharmacy is to inspire patients to live a healthier lifestyle and to provide exceptional pharmacy services in partnership with patients and colleagues. I currently am the corporate lead on a national initiative dedicated to transitioning the pharmacists away from a dispensing role and towards consultative services that are focussed on disease state training and nutritional and lifestyle counselling.

I am an active participant in provincial regulatory and advocacy groups and have faithfully attended district, special and annual meetings for the last 25 years. In April, I was elected to the MSP board of directors and was appointed chair of the professional relations committee. I am proud to advocate for the professional and economic interests of the members.

Some may try to convince you that community pharmacists want voting rights so that they can advance their own financial or commercial interests at the expense of protection of the public. I am a community pharmacist. I have authored two CCCEP accredited continuing education programs dedicated to the identification, prevention and handling of medication incidents and errors. The day any pharmacist, hospital or retail does not care about the well-being of their patients is the day they should leave the profession.

Madam Vice-Chairperson in the Chair

It is my view that if members had supported the most recent draft of the regulations, the MPhA council would not have passed a motion without consultation with the membership to strip away our voting rights. Many of us, in fact, would not be here today. This is indicative of a problem, and that issue is simply one of trust.

In its 2007 report, Self Regulated Professions, Balancing Competition and Regulation, the Competition Bureau offered six guidelines for regulators to consider when developing regulations. This report was, in part, a reaction to competition-stifling regulations being imposed upon professions such as pharmacy.

I'm not going to read all of the guidelines to you, but, in short summary, the regulations should have clearly defined and specific outcomes. The regulations should be linked to clear and verifiable outcomes. The regulations should be the minimum necessary to achieve the stated objective. The regulatory process should be impartial and not self-serving. A regulatory scheme should allow for periodic assessment of its effectiveness and be subject to regular reviews, and finally, a primary objective of the regulatory framework should be to promote openly competitive markets.

In March of 2008, 66 percent of the voting membership rejected the MPhA's proposed regulations. I submit that this is not because the profession of pharmacy is hopelessly at war with itself but because the MPhA has not crafted regulatory proposals using the guidelines offered by the Competition Bureau.

The registrar of the MPhA asserts in his annual report that the Competition Bureau report is not applicable to health-care providers. I'm confused by this statement given that the council endorsed the recommendations of the practice directives ad hoc committee which drafted their final report using the Competition Bureau guidelines. I sat on that committee and approved the final report, as did the president and vice-president of the MPhA.

I'm not proud to tell you that I voted against the regulations last year. I felt that some of the regulations were self-serving and were not impartial and that the MPhA used the claim of public protection to justify their proposals when they were unable to demonstrate a need for the regulation to exist. One example concerned pharmacy manager qualifications.

You are likely aware that all provinces have signed a mutual recognition agreement to address the mobility of qualified pharmacists between provinces. This seems reasonable given that the rules and responsibility of a pharmacist are essentially the same throughout Canada. However, the MPhA has proposed additional demands on pharmacy managers that would have made it more difficult to recruit pharmacists to Manitoba, particularly rural locations.

I ask how the public is protected when the 10 rural pharmacies I supervise in places like Flin Flon, The Pas, Dauphin, Swan River are unable to recruit pharmacists because of needless regulatory hindrances. Who is going to service the three nursing homes that we currently look after? How is the public interest served when competition is stifled in that market, when prices go up, or when the pharmacist talent pool is restricted or ultimately when our pharmacies close?

When pressed to explain why they have taken this extraordinary position on pharmacy manager qualifications, the MPhA will answer that there have been problems with new graduates who assumed managerial roles. When asked for metrics comparing the number of incidents involving new graduates versus old graduates, none are forthcoming. If you can't measure it, how do you know you have a problem? If the regulation does not have a clearly defined specific objective, or cannot be linked to a clear and verifiable outcome, why does it exist?

As another example, the MPhA has not been adequately able to adequately demonstrate that loyalty programs offered on a consistent day-to-day basis adversely affect patient care. Loyalty programs are commonly used in the retail sector to recognize a consumer's patronage and are comparable to many other free items that a pharmacy may provide: AIR MILES, parking, delivery, coffee. The question to ask is whether inducements harm the public and not whether the removal of inducements protects the public. There is no evidence to support a ban on loyalty programs, and the MPhA should not be interfering with conventional business practices. Again, a primary objective of the regulatory framework should be to promote openly competitive markets.

One of the books that I recently read is entitled *Good to Great* by Jim Collins. As the title implies, it

provides some insight into why some achieve greatness and others, mediocrity.

It has to start with an honest effort to determine the truth of your situation and the ability to make the right disc–decisions regardless of how difficult they may be. You must create a culture where people have an opportunity to be heard and for the truth to be heard.

You must lead with questions, not answers. You must engage in dialogue, not coercion. You must conduct post-mortems without blame and name calling. You must motivate, not demotivate your members, and you must trust.

Council's attempt to strip members of voting rights without consultation is not indicative of an organization committed to these goals. Embrace the people who care enough about their profession to speak out and who make suggestions for positive tran–change and you truly will transition from good to great.

Thank you for the opportunity to speak today, and I confirm that I am in support of Bill 18 in its existing format.

***** (20:50)

Ms. Oswald: Yes, thank you very much, Ms. Romanetz, for your presentation. I thought it was all excellent. I was captive–captivated, though, by one line in it: this is not because the profession of pharmacy is hopelessly at war with itself. I think, maybe, in some other words, I might have implied that earlier this evening. And I here–I am hopeful that you are bang on in what you are saying.

Is this going to ever be solved that the two sides–and I actually know there are more than two sides. There are smaller subgroups and so forth. But will pharmacy find its way to have the issue of voting rights, perhaps even be a moot point, where decisions can be made in a consultative, collaborative way and that a group, whether it's the MPhA or a council of some kind can come forward to whomever is in government and propose that which is right for the profession. And if so, you know, if indeed this, this is so what you've written, how do you think that could happen?

Ms. Romanetz: I hope in a perfect world that, indeed, would happen. I don't think pharmacists are focussed on fighting. We have no desire to use up valuable time that we could be dedicating to other initiatives, such as what I mentioned today, including, you know, educating our existing staff to take a different direction in their practice. I hope that that day comes when we can trust each other enough that we don't have to worry about voting rights, but at some point when you reflect on the past, you have to draw a line in the sand and you have to wonder why people in a position of power have purposely misled you.

I think that the PricewaterhouseCoopers initiative–and I was fortunate to be one of the pharmacists that had an opportunity to speak to that organization–is the beginning to an end where we can move on to a more productive use of our time.

Ms. Oswald: Yes, and just as a follow-up to that process, indeed, the member asks about the funding of that process and, yes, government is supporting the PricewaterhouseCoopers mediation consultation, whatever name we want to call it. And, of course, such a proposal came forward about a year ago, in addition to other interventions that government has tried to make in assisting with collaboration and consultativeness and co-operation, respecting of course the organization's desire to be independent in its journey.

Do you think that that mediation of some variety is going to be the means to an end where perhaps the war might come to an end? Is that the answer, or is it mediation plus other things that you might recommend?

Ms. Romanetz: Well, I can tell you that I don't envy the MPhA's task of developing regulations. I attended all of the various meetings that were convened, and I can tell you it wasn't an easy task for them, and many times I left and I was encouraged by the progress that we were making. For the time first, pharmacists were having face-to-face dialogue and, you know, in my world that's something that happens fairly frequently. And you have an opportunity to state your case and if you don't state it, then you go home and you accept it and you move on, and I approach those meetings in the same format. And I was actually optimistic that we were making some great progress. And I was very discouraged to find the council had passed this motion on April 17th and all of the wounds from 2006 are back, and it's not necessary and the timing is not right. Pharmacists need to heal, and we need to trust again, and the benefit will be enhanced patient care in the province.

Mr. Gerrard: Thank you for your presentation. Now, as a community pharmacist, I asked a question earlier on, and I was told that one of the differences

that seems to be important is how the technical pharmacists or the technical work is done. I mean, is there a big gulf in terms of community pharmacy to hospital pharmacy in terms of technical approach and requirements?

Ms. Romanetz: Well, currently there is. Currently, retail pharmacy still operates under the existing regulations, and there has been some changes made in the hospital to facilitate programs such as tech-check-tech. So, you know, there is some distinct differences, and we're looking forward to the day when not only pharmacists, but also technicians can take on a broader scope of practice and pharmacists can wor–move away from the technical lick, stick and pour functions and focus on what's truly important, which is enhancing the overall health of their clients.

But to answer your question, there is some–it's not a completely level playing field, and I don't say that with animosity, it's just a simple state of affairs.

Madam Vice-Chairperson: Thank you very much. The committee calls Colleen Metge from the Faculty of Pharmacy, University of Manitoba. Thank you very much. You can proceed whenever you're ready, Ms. Metge.

Ms. Colleen Metge (Faculty of Pharmacy, University of Manitoba): Just for the record, my name is pronounced Metge.

Madam Vice-Chairperson: Could you say that one more time?

Ms. Metge: Metge.

Madam Vice-Chairperson: Metge. I apologize.

Ms. Metge: Thank you, Madam Chair, members of the committee, ladies and gentlemen, good evening. My name is Colleen Metge and I'm a pharmacist and an associate professor at the Faculty of Pharmacy at the University of Manitoba.

I'm here tonight representing members of the Faculty of Pharmacy which includes the eight present here with me this evening. The Faculty of Pharmacy appreciates that the drafting of The Regulated Health Professions Act has been a long and arduous process but one that was overdue. The government is to be commended for modernizing health professions' legislation and for developing a common legislative framework under which each profession is to practise, so thank you.

Having said this, members of the Faculty of Pharmacy believe that the principle of a common legislative framework is in jeopardy. Specifically, we oppose the inclusion of section 210 and 211, parts 1 and 3, in the proposed Regulated Health Professions Act. This section of the act will grant the authority for recommending regulations and a code of ethics to all regulated members of the College of Pharmacy, instead of its elected council. The inclusion of these sections are inconsistent with all other health-care professions to be governed by the provisions of the proposed act.

In essence, pharmacy is being treated differently under the act. Members of the Faculty of Pharmacy believe that this will impede the profession's ability to approve regulations that support public safety in a timely and efficient manner. I'll come back to this different treatment provision in a moment.

Although we agree with the Minister of Health's (Ms. Oswald) charge that this legislation is to be clear, workable and effective in regulating health professions in the public interest, creating a different process for how pharmacy is regulated, we maintain, will compromise the government's intent, and I'm quoting from the health professions regulator reform consultation document, provide consistency in the powers and duties that it regulates to regulator bodies, while strengthening patient safety, transparency and accountability.

We also maintain that a vote by all members, as is currently proposed in sections 210 and 211, would virtually eliminate the voice of the public representatives on council. Furthermore, requiring a vote by all the regulated members of the College of Pharmacy may not always work in the public's best interest. At times, the council may need to recommend regulations that will directly protect the safety of the public, but may be less popular with its regulated members.

Examples of this include the implementation of pharmacists' profiles on the Internet and publishing the names of professionals that may have been disciplined for substance abuse on the job, as was seen in the recent discussion of nursing, and probably also includes the delay in passing regulations to support Bill 41.

Pharmacists are health-care professionals and I have every confidence that they will be con–they will continue to care for and have concern for the safety of their patients. However, we believe that the most efficient, effective and workable means to

maintain this care and concern is by removing section 210 and 211, parts 1 and 3, of The Regulated Health Professions Act. If the act is changed accordingly, then the council of the College of Pharmacy will still be required to consult with all regulated members on all proposed regulations and changes to the code of ethics as described under RHPA 82, and done by virtually all other health professions across this country.

I promise to address why pharmacy seems to find itself separated out in this legislation in section 210 and 211, and why, as demonstrated by previous comments, and Jon Gerrard, on May 14th, when he said, groups of people within the pharmacist community have very, very different and very strongly held opinions on this–on these particular clauses.

***** (21:00)

I feel that I can speak of these apparent differences in an historical context as I have worked in pharmacy, both community and hospital, for over 40 years in three western Canadian provinces and the state of Maryland so have lived a lot of the recent history of pharmacy.

I served as the president of the College of Pharmacists of B.C. and have also written a chapter on pharmaceutical policy in a Canadian textbook called *Safe and Effective: The Eight Essential Elements of an Optimal Medication-Use System*, which outlines the role of pharmacists in the use of medicines.

I also teach the Principles of Professional Practice course for third-year pharmacy students, including ethics and professionalism. Using a historical lens, then, may help to understand what may be at the root of these very different and strongly held opinions of–within pharmacy.

In a nutshell, we have had a new pharmacy act in place since December 2006. At the time, it was one of the most progressive pharmaceutical acts in Canada with respect to improving patient safety, accountability and also to ensuring that pharmacists will be able to better meet the needs of patients. However, the act's implementation has been held up because the profession has had difficulty agreeing on the regulations needed for the act to become operative.

The current disagreement over the inclusion of section 2–210 and 211, (1) and (3) appears to be an extension of this internal standoff on regulations. Hence, my attempt tonight to describe why action in the profession appears to be so diverse, using a historical lens.

Pharmacists and physicians up until the first part of the 1900s worked hand-in-hand to help the patient. Physicians made the deferential diagnoses, and the pharmacists procured, stored, compounded and dispensed the treatment, *secundum artem:* according to the art.

However, once medicines began to be massively produced and marketed by the pharmaceutical industry, the pharmacists essentially lost three of their four societally recognized roles. By the mid-1950s, pharmacy was left with what everyone thought was its remaining and recognized role: the safe dispensing of prescription drugs. Couple this largely technical function with professional isolation by virtue of location–the basement of hospitals, the pharmacy in a strip mall–and you have a profession which has been easily and repeatedly misunderstood, underestimated and undervalued.

Madam Chairperson in the Chair

However, others, and not just pharmacists, at the time and since, have maintained that pharmacists do have another function which until recently was not very well recognized in legislation outlining pharmacy's roles. Variously called clinical pharmacy or pharmaceutical care, the legislative framework for allowing for these patient versus more dispensing-oriented roles has been slow to evolve. Times are changing, though. Pharmacists are being educated and have the ability to ensure that all medications are both used and dispensed safely and effectively.

In faculties of pharmacy across Canada, our programs reflect that pharmacists are the only health-care professional who knows the physical and chemical properties of drugs and their pharmacologic and therapeutic properties, and who has the ability to monitor their safe and effective use in partnership with the patient, his or her family and the prescribing physician.

Across the country, governments, pharmacists and other health-care professionals are supporting the development of this other, more patient-focussed role, largely through legislation. For example, the government of Manitoba recognized this in the passing of Bill 41, the new Pharmaceutical Act, which is said to enhance the role of the pharmacist, should a pharmacist choose to do so, for the public good once regulations are passed.

What has taken this recognition of the other role of the pharmacists so long to come about? The dispensing-oriented, community-based practice of today is the dominant model of practice, largely because remuneration of the individual pharmacist is tied solely to the dispensing of a prescription rather than the inclusion of a service like pharmaceutical care. As a result, community pharmacists tell us that they find themselves frustrated that the dispensing role leaves them less time as well as minimal economic incentive to practise a more enhanced patient role, one that they have been educated and trained to do so and which society desperately needs.

Inclusion of section 210 and 211 in the new health professions act will help to maintain a largely dispensing-oriented role for pharmacists when they should be given the option of doing so much more. Inclusion of 210 and 211 will impede pharmacy's ability to approve regulations in a timely and efficient manner. A regulatory process consistent with the other professions is needed to support those pharmacists who want to further develop their patient focus role. In essence, not treating pharmacists like the other health-care professionals who will hinder the progress of recognizing pharmacists' enhanced patient focussed roles.

Before wrapping up, I thought I'd describe what these are. They have been described for the last 20 years by the term pharmaceutical care and previously as clinical pharmacy. The term is allied closely to medical care and nursing care, and I've made the distinction in an attachment to this presentation. It is the responsible provision of drug therapy by pharmacists in partnership with patients and physicians. It is distinguished as needing to be separate from the pharmacist's distributive or dispensing role. It is a practice role that is in addition to the dispensing role, and it offers society a function that helps prevent drug-related morbidity and mortality.

From Canadian studies, we know that 72 percent of drug-related problems are preventable and from these data, that 17 to 24 percent of hospitalizations are both drug-related and preventable. One in nine ER visits are related to medication issues; again, the majority of these are preventable. I keep mentioning preventable because when the pharmacist has the time and recognition through legislation to practise pharmaceutical care or an enhanced role to ensure safe and med–effective medication use, then everyone will be better served.

Pharmacists working in the community and hospital settings want the option to offer and be recognized for their ability to more effectively help people with their medications. This was begun under the passing of Bill 41 and will be supported by The Regulated Health Professions Act, but for one exception. Members of the Faculty of Pharmacy maintain that inclusion of section 210 and 211, sections 1 and 3 will hinder the timely and efficient development of regulations and a code of ethics that are needed to make medication use safer and more effective in the province of Manitoba.

Thank you.

Madam Chairperson: Thank you, Ms. Metge.

Ms. Oswald: Thank you very much for your presentation. It's comprehensive and beautifully written.

In some of the discussion about treating pharmacists the same as the other professions, one of the ideas that has been brought to the table would be, you know, as, as the act go, goes forward and the, the MPhA essentially becomes the college of pharmacists, perhaps they should have the same role as the other professions do and the issues concerning licensing of facilities and, and so forth should be peeled away from that mandate. You know, it's not one that exists for the other professions. Let's just take that away and have another body that might deal with that specific issue of the retail and, and someone else is going to decide whether or not an internest–Internet pharmacist can have a business, for example.

What would you make of that kind of a proposal? We'll, we'll treat the new college of pharmacists the same as the other colleges because, indeed, they, they will have similar roles and, indeed, no longer have roles that the MPhA might currently have. What do you make of that?

Ms. Metge: I think that's a revelation. I know that it has been proposed previously to this government to do just that. I don't think it's proceeded very far, but I have to say that maybe we do need a mixed market of human resources for, for largely community pharmacy and hospital pharmacy to maintain a comprehensive range of pharmacy-based public-health services. And so the idea you are proposing is probably one well-founded on–needed to be pursued a little bit more strongly.

Mrs. Driedger: Thank you, Ms. Metge. Your historical perspective is interesting, you know, to

look at it the way you presented it. It raised a thought for me and that was how long-standing has the divisiveness been there within the pharmacy profession? Is it something that's been really long-standing? Is it more recent? Why is it there? And the minister just referred to it as a war. Is it really that bad?

Ms. Metge: Is it that bad? I was sitting in my seat earlier and thought that, really, this argument has not gone on to this extent in other jurisdictions–in other pharmacy–in other jurisdictions that have pharmacy laws. I originally came from British Columbia, and we pa–we–we passed very, very progressive standards of practice laws back in the 1970s. When I arrived in Manitoba I realized that the standards of practice were quite loose in this province. And, in fact, I will give you an example.

I remember arguing to the members of the Pharmaceutical Association that they were about to pass the 1983 code of ethics that had been passed by the American Pharmaceutical Association in 1983, and they had, seven years earlier, passed a different one talking about this covenantal relationship that the pharmacist should have with the patient, which all other health professions operate under.

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So I think it really is a made-in-Manitoba kind of situation. Most other jurisdictions in North America have resolved this. They recognize that public members are needed, and they recognize that it's a privilege that a profession has to have their members elect their own members to serve society. The professions are there at the behest of the public. So how long has it been going on? It's–for me, it's been going on for at least 10 years in this province, but I don't see it as having been gone on in other jurisdictions. We are unique.

Mr. Gerrard: Thank you, Colleen. Just a question. Are you suggesting that the community-based pharmacies are not ready to go as far in terms of the model that you describe, that is, checking on the drugs and the interaction, and the use of the patient and not just in the dispensing?

Ms. Metge: I believe that community pharmacy is ready, and certainly the last 10 graduating classes are more than ready. However, I do believe that there is a great deal of fear out there about the proposed changes to the practice of pharmacy, and I think pharmacists are trying desperately to hold on to their livelihood, which is largely garnered from the dispensing of a product at the moment, and also the threat of maybe encroaching powers that are being supported by pharmacy corporations around the use of technicians.

You know, pharmacists actually lost their right to control their front-line practice when private corporations were granted ownership rights to pharmacies in the 1970s so this didn't happen in Saskatchewan, and I certainly think the relationship that the Saskatchewan College of Pharmacists has with its regulated members is not as divisive as you find here because pharmacists are employed at the behest of private employers. They don't run their own practices. Some of them do, but large corporations are actually–have another mandate and that is to reward their shareholders. I respect that. That's what it's like.

But on the other hand, we're educating pharmacists that are prepared to help society use its medications better, and I think the passage of regulations will help to support that intent that is already currently in the act to do that. A pharmacist doesn't have to change their practice. They just need the ability, the permission if you will, that the act will give them the ability to expand their scope of practice.

And I don't think it's a hospital and community pharmacist issue. I practised in community for 18 years and I had a long-term care practice that gave me a day off a week to work with physicians and nurses on better medication management for the patients of long-term care facilities. This is not a community hospital issue. This is the two separate roles that I think pharmacists can fulfil but that the choice for pharmacists to fulfil that professional pharmaceutical care role has to exist.

Madam Chairperson: Thank you, Ms. Metge. Thank you for your presentation.

Next, I'd like to call on Tim Pattern. Is Mr. Pattern here this evening? Welcome. You can start whenever you're ready, sir.

Mr. Tim Pattern (Private Citizen): I would like to thank the committee for an opportunity to speak. My name is Tim Pattern. I'm presenting before this committee as a private citizen.

I have been a member of the Manitoba Pharmaceutical Association for over 26 years. During that time frame, I've also been a member of the Manitoba Society of Pharmacists, of which I'm currently a board member. Since my graduation from

the University of Manitoba Faculty of Pharmacy in 1983, I've practised as a community pharmacist providing front-line care for my patients.

Over the last quarter century, the profession of pharmacy has progressed greatly. I feel confident that it will advance even further in the future. However, it can only advance if there is a fostered spirit of co-operation among its members. Pharmacists as a group are very diverse in their practice settings. Pharmacists practise in the public sector, in academia, in industry, in distance care. However, the vast majority work in community pharmacy. Each practice setting is unique with its own challenges and with its own special requirements for providing patient care.

Pharmacists are the only health profession in Manitoba that requires its college to license practice sites, thereby regulating the more commercial aspects of the profession. There have been on occasions where this mandate has caused some debate, as in the area of international pharmacy provision as outlined in the Craig Murray report.

When drafting regulations for such a diverse profession, viewpoints and interests of the membership and stakeholders are paramount. By encouraging engagement from the approximately 1,100 front-line pharmacists, the council has an invaluable resource to draw from. Without input from the membership, well-meaning proposals from council to advance the profession may inadvertently negatively affect other areas of practice. When the membership is engaged and free to express their concerns and propose compromise solutions, positive results are possible. A process that encourages engagement, open discussion and compromise can ultimately lead to a position that can be voted upon by the membership. A vote with broad-based support from the membership delivers a clear mandate to council. Regulations developed in such a manner produce better public policies when they can be adopted by government.

Pharmacists within Manitoba have had a long history of voting on regulations and codes of ethics. This model has served the public well. I'm happy to see that the proposed regulated health professions act is sensitive to the needs of pharmacy. We must remember that pharmacy does not enact regulations– only government can do so–but it is upon pharmacy to present to government the best possible proposed regulations. By engaging and distilling the vast number of viewpoints within the profession, regulations can be developed that represent forward-thinking ideals, concerns for patient care, compromise and public interest.

This very issue of membership voting rights was considered by the Legislature less than three years ago when developing Bill 41, The Pharmaceutical Act. Bill 41 was passed with unanimous support from all parties in the Legislature in 2006. What was in the public interest then is still true today. It must be noted that the proposed regulated health professions act also allows for the possibility of ministerial powers to be enacted if it is deemed in the public interest. These ministerial powers could allow for directives to be enacted upon the council, if necessary. It is therefore in the interest of the profession to enact regulations that are in the public interest and provide optimal patient care.

Recently, the Manitoba Pharmaceutical Association council passed a resolution that would remove pharmacists' long-standing voting rights. This motion was passed without consultation from its membership and to date has been done so without any formal explanation to its membership. This past week, the Manitoba Society of Pharmacists conducted a survey amongst its membership regarding pharmacists' voting rights. The results of the survey showed that over 90 percent of pharmacists were in favour of preserving this right.

After the passage of Bill 41, The Pharmaceutical Act, the Manitoba Pharmaceutical Association presented the draft regulations to its membership after what it defined as a consultative process. When the regulations were brought to a vote, 66 percent of voting pharmacists voted down the proposal. It should be noted that the release of the draft regulations occurred in the middle of a facilitation process between the Manitoba Society of Pharmacists, the Manitoba International Pharmacists Association and the Manitoba Pharmaceutical Association. Mr. Craig Murray was the facilitator on this issue and his final report, he states: It was difficult to completely reconcile MPhA decision in this regard and considered most confounding. MPhA decision to release the draft regulations had a profoundly adverse impact upon the recently established fragile rapport, professional relationships and tenuous accomplishments of the process. Attached is the Craig Murray report.

Currently, the Province of Manitoba has appointed the services of PricewaterhouseCoopers to help facilitate the regulatory process issues between

the Manitoba Pharmaceutical Association and the Manitoba Society of Pharmacists. One of the issues currently under investigation revolves around the organizational capacities of the Manitoba Pharmaceutical Association in fulfilling its mandate. To date, these reports have not been completed.

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The potential for pharmacists to lose their voting rights on regulation changes at this critical time presents obvious complications, potential adverse impacts, and undermines the current regulation development process. The provisions regarding pharmacists' voting rights in Bill 18 mirror those that were unanimously supported by the Legislature in Bill 41, The Pharmaceutical Act. The rationale for promoting a contrary posi–position is not reflective of the public interests.

As we wait for the results of the Pricewaterhouse report it is important that the profession of pharmacy work towards an atmosphere of mutual understanding, respect, collaboration and compromise. These are the building blocks for developing and moving forward innovations within the pharmacy profession. These are the building blocks Bill 18 is presenting and is allowing each self-regulated health profession to work with in the future. Thank you.

Madam Chairperson: Thank you, Mr. Pattern.

Ms. Oswald: Yes, thank you, Mr. Pattern, for, for a fine presentation.

I've asked this question in, in different ways to different presenters, and, and I'm going to try with you as well. We know that there has been a divide between different groups in the profession of pharmacy and, and there have been a number of references to the 66 percent of members voting against the proposed reg–regulations.

Do you believe that there are any conditions under which people that belong to MSP would support regulations, you know, crafted by MPhA? Like, would there ever be a time where, where there might be a really great vote in support of, or, or is there a relationship issue here that's very real that, that, perhaps, might be insurmountable?

Mr. Pattern: I would like to think that would be possible. I think what, what has to happen, though, is if feedback from the membership has to be listened to from the MPhA–during the Bill 41 process, pharmacists were encouraged to write in their suggestions. A lot of, a lot of the suggestions that were put forward by the members were not reflective in the proposed regulations that were given back and, in fact, there were lots of issues, new issues, in the last draft that were never discussed by any of the membership.

So I think it's a two-way street. If you really want input or feedback from the membership, you have to be able to listen and to compromise, and that seems to be the stumbling block.

Mrs. Driedger: Thank you, Mr. Pattern, for your presentation.

We've certainly heard tonight, and it's, it's being reinforced, certainly, more that the divisiveness is, is quite prominent within the profession.

Were you surprised when this bill was brought forward before the Pricewaterhouse report had been finalized, and do you think that had the process happened earlier on, you know, even back in 2006, 2007, that we would be in a better position now for this legislation to go forward? Was there some lag time here that should have been prevented and Pricewaterhouse brought in much sooner?

Mr. Pattern: I think both the Manitoba Pharmaceutical Association and the Manitoba Society of Pharmacists were given some marching orders, if you will, to get their houses in order. Unfortunately–and we were given time to do that and, unfortunately, that didn't occur. So it might have been premature to bring in Pricewaterhouse at that time.

As far as Bill 18 coming up when it does, I mean, again, we are just one profession amongst a slew of others. So I, I can understand why the bill would be presented now. There didn't seem to be any need to wait for pharmacy to get their house in order and hold back all the other professions. It's just the way it is.

Mrs. Driedger: Do you think the, the pharmacy group out there would have had its house in order, though, had Pricewaterhouse had a longer period of time to, to be involved and those marching orders been given a few years back, and then we might have avoided some of this extra inflaming of the situation that seems to be occurring now?

Mr. Pattern: I guess hindsight is 20-20. At that time, I think there was optimism that MSP and MPhA could reach agreement. I mean, I, I felt very

optimistic, personally, and, unfortunately, that did not unfold.

Mr. Gerrard: Thank you, Tim.

Just, I mean we've heard from Colleen Metge that the, you know, the changing nature of practice, the wanting to incorporate a lot more decision making by pharmacists and not just, you know, handing out pills or so on is part of the basis for the difference. I mean, is that your read on, you know, where the problem lies or, or is it in a different area?

Mr. Pattern: I think that some of the rea–we are a diverse profession. You know, you know, pharmacists work in many different areas, and it's, sometimes it is difficult and challenging to come up with the one-size-fits-all regulation. Perhaps, perhaps regulations should be drafted according to type of practice. I mean, I haven't discussed that with my colleagues, however, perhaps that is one road of compromise that we could go down, and, therefore, you know, the, the acrimony could lessen.

Madam Chairperson: Thank you very much, Mr. Pattern. Thank you for your presentation.

Next up, Sandi Mowat. You may begin whenever you're ready Ms. Mowat.

Ms. Sandi Mowat (Private Citizen): Thank you. My name is Sandi Mowat and I am the president of the Manitoba Nurses' Union, and thank you for giving us the opportunity to present to you this evening.

The Manitoba Nurses' Union represents 11,000 nurses in all regions of Manitoba. Our nurses work in acute care, long-term care and in the community. As an organization our mission is to advocate for our patients and for nurses. Both of those roles bring me here to speak to you this evening.

I am here to speak on the sections of the proposed legislation which specifically deals with the naming or, as our union members call, the shaming of nurses struggling with addiction.

In April of this year, we held our annual meeting. More than 500 nurses attended this event. A resolution was passed calling upon the College of Registered Nurses of Manitoba to stop publishing the names of nurses in their magazine and on their Web site who were disciplined for drug abuse. The resolution was also amended to include the colleges of licensed practical nurses and psychiatric nurses in Manitoba, although, it is our understanding that the latter two have chosen not to publish names at this time.

How will publicly naming or shaming nurses help nurses or patients?

In our research on this subject we found no evidence that the public naming or shaming of nurses struggling with addiction would in any way protect patients or support the nurse named. In fact, all indications and all addict specialists we spoke to said it would have the opposite effect. To be publicly shamed or even the fear of being stigmatized could cause a step back in their recovery or discourage them from dealing with their addiction because they–of the fear of being publicly exposed.

The resolution to our AGM was actually brought forward by nurses out of concern for a co-worker. The individual was a recovering addict who had completed a rehab program and had stopped using drugs several years ago. She was practicing as a nurse, but abided by the restrictions imposed on her licence. She was told by co-workers that her name was on the college Web site and in their magazine. She looked on the Web site and found that it was not only her name published; also on that Web site was where she worked, her history of drug abuse, that she attended meetings and was subject to run–random drug testing, was also included on that site. Luckily, this woman was able to maintain her sobriety in the face of this public humiliation. Had she been newly sober she could easily have relapsed.

In addition to the emotional turmoil on her and her family, she lost out on job opportunities and her reputation with co-workers was destroyed. Now, being branded as an addict, she's automatically the first suspect of any infraction. Recently, some narcotics went missing at her workplace; her colleagues automatically assumed it was her. It later came to light that the drugs went missing when she was not working.

No matter how much progress she makes, she will carry this stigma for the rest of her life. We believe this does nothing to protect the public.

How is the public protected? If a nurse is found to be suffering from an addiction to drugs or alcohol, there is a discipline process. Employers may suspend the nurse and/or put restrictions on his or her licence. The nurse will be required to abide by restrictions that may include a restriction on the number of hours she or he may work; a minimum of 14 random drug tests; provide the college with copies of all

medication prescriptions; and attend a 12-step program twice a week. That is enough to protect the public.

***** (21:30)

Ninety-nine percent of nurses in this province are employed in facilities or in the community and have RHAs or the government as their ultimate employer. They are subject to the rules and regulations of that employer.

It has come to our attention that a nurse who comes forward with an addiction problem and wants to remove his or her name from the nursing registry while dealing with the addiction is also subject to having the name published. The threat of losing your professional reputation for life would certainly be a strong deterrent for someone to come forward voluntarily. The problem is enough to deal with. Public humiliation and losing one's career is often too much.

British Columbia has dealt with this issue in its legislation. The publication of the nurse's name is prohibited when the person has admitted the addiction. That should be the precedent that the government of Manitoba should follow. I would suggest that a section be added to the bill stating that, when a person admits that he or she suffers from an ailment, emotional disturbance or addiction that impairs his or her ability to practise, the college, whether through the complaints investigation committee or otherwise, must not publish the name of the investigated member nor any personal health information about that investigated member where it would otherwise be permitted in the act.

Drug addiction is a serious illness that requires a supportive environment and treatment. Many people with this illness are afraid, isolated and broken when they start treatment. It is an extraordinarily difficult time for anyone. Even while working with a restricted licence, the nurse who is trying to regain her or his health is subject to a great deal of stress in a very demanding profession. The daily stress of nursing combined with battling drug addiction can be overwhelming. The nurse requires monitoring and support to return to life as a fully functioning caregiver. Support is the key.

We believe that publishing the name of the nurse as she or he struggles to regain health is a terrible way to show support. It is kicking someone when they are down. Our union believes that the publication of the names with the illness of drug addiction also brings up privacy issues. In Manitoba, we have put stringent safeguards to protect people under our Personal Health Information Act who are deemed ill. We believe that nurses should be extended the same right to privacy as they deal with their health issues.

Publishing the names of nurses is, in our opinion, a violation of the Human Rights Code. The code states that a person cannot be treated differently as a result of an illness or a disability. Addiction is an illness, and nurses should not be treated differently. In researching this issue, we found that other provinces such as Ontario are cautious about printing names of nurses or other health-care professionals. The Ontario Nurses' Association was successful in getting amendments to their health professions act, which made it more difficult to publish nurses' names. The evidence of public interest must be compelling, more so than in the legislation that is now being proposed in Manitoba.

Recently, I opened an issue of my college magazine and read about a nurse who was disciplined for professional and–misconduct as a result of drug addiction. Her name was printed in large type at the top of the article. Unfortunately, in smaller type at the end of the article was a note saying that this was not the nurse by the same name who worked at a large hospital in Winnipeg. I wonder how many people made it to that disclaimer. So now two nurses will have to carry the stigma of addiction. Interestingly, the nurse who had been disciplined had not worked for several years.

The colleges of nursing have the responsibility to pro–protect the public. We understand that. We are well aware of that role. We believe that potential employers and the public have the right to professional, safe, quality care. All nurses in Manitoba are registered with their licensing bodies. Anyone is able to contact the colleges to ascertain the status of any nurse on that registry. That, in combination with the discipline process, we believe, safeguards the public.

As the representative of over 90 percent of nurses in this province, we ask the government to take another look at this legislation and ensure the rights of all individuals are protected. We believe that all our members are devoted to their patients and want the very best for them. We also want the right for our members to deal with their illness in private, with dignity and with support. Any Manitoban deserves that much. Thank you.

Madam Chairperson: Thank you, Ms. Mowat.

Ms. Oswald: Well, thank you very much, Ms. Mowat, for being here tonight to present, you know, this very passionate, emotional, indeed, and serious issue. We know that, over the course of the time that we spent consulting on this legislation, and even during the time of the consultation document, this, this specific issue wasn't raised during that time, but just shortly thereafter. And I think there's been a very important, you know, public debate that has gone on on this subject. And I think that Manitobans owe you a debt of gratitude for that, for bringing this, this conversation forward.

Unfortunately, I believe there's nobody in this room tonight that has not, in some way, dealt with a loved one, a family member, a friend who has been living with an addiction, and I include myself in that group. And to watch what happens to somebody, the impaired judgment, bad decisions, it's painful in the extreme. And so one could come to understand, I think quite quickly, why the public might think if there's somebody at my bedside that might be like that, then everybody should know.

And then there's the argument that you have, I think, very beautifully articulated tonight, and in other places, and that is that there are many steps in place for nurses to, to take to seek help, and indeed, and especially in cases where a nurse's licence might be revoked and then a decision to, in addition to that, publish their name for all the world to see is nothing more than kicking them when they're down. And I really take those comments to heart and all of the steps in between where the naming, the shaming, and what is the ultimate goal of everyone here but to provide the best possible situation for a patient. All of these things need to be taken into account as we go forward with this legislation.

So I will review your recommendations about the other jurisdictions that have legislation that is superior, in your view, and we will go forward to make the best possible decision. I know that this has been a very passionate journey for you and I, I want you to know that I believe it has not been in vain. Thank you for being here tonight.

Mr. Gerrard: Thank you, Sandi, and I agree with you. But I think that part of what we need to do to be able to reassure the public is to make sure that where you've got somebody who's a nurse, who is working in an environment and they've got a problem with addic–an addiction, that they are supported and monitored in a way that's going to, you know, guard the public's safety. Right? And so the question becomes, you know, who needs to know? How do you make sure that that monitoring and support is in place when you have a nurse working? So, over to you to tell us.

Ms. Mowat: Our position would be that the college already knows, so there's restrictions on that nurse's licence, and they have to abide by the restrictions on that licence. And I know what you're going to say to me after that because who's going to be watching that? Well, obviously, the employer has a responsibility as well. They know that the nurse that is working for them has restrictions on their licence, and they all agree to have that nurse come back to work, and so those issues are dealt with at that time.

The other, other issue that does come up is that that nurse–people may not know that that's where, why she's been away and the problem she's having now that she's back from sick leave or whatever. But we also have responsibilities as nurses; if we see any behaviour that we believe is putting our patients in danger, then we have a responsibility as well to deal with that. So we need to deal with our colleagues as well.

So there's about three checks and balances in place for these nurses as they go back to work.

Mr. Gerrard: Yeah, I mean, I think it's probably pretty important for the immediate supervisor to be in the loop and know, and, and that–so that you can put up a, you know, as you say, a supportive environment, one that monitors but does that in a positive way that helps to ensure that you don't have problems happening.

Ms. Mowat: I would agree that certainly the employer would–could–does have the ability to tell the person who's, the person is working for who would be a management person, that these conditions are–exist, these restrictions exist. And again, that can be done simply by the normal lines of communications instead of that supervisor having to go on the Web site and click on that nurse's name and get to read the whole personal history, which you can all do right now.

***** (21:40)

Mrs. Driedger: Thank you, Ms. Mowat. You've made a lot of really good points about an illness, which is what addictions are. I can recall working with a nurse who was an alcoholic, and you know, was in that situation at work, and she had a lot of struggles, and she may not have been able to

overcome them if, perhaps, you know she had had to go through a process that you articulated in here. And I can recall working very closely with her to, you know, work through this illness and it really was that for her.

Are you concerned that the legislation, the way it is written right now, is open to abuse of interpretation or abuse of how it might be utilized? Does it need to be tightened up? Does it need to be changed to be more similar to what other provinces have in place?

Ms. Mowat: Yes, I think that Ontario, for example, has tightened the language that basically says the name would only be published if the good to the public or the safety of the public outweighs the publishing of the name, and that is stronger language than the proposed amendment has–than the proposed language has. Sorry.

Madam Chairperson: Thank you, Ms. Mowat.

Thank you for your presentation.

Next, a little change in the order, ask the committee's indulgence on. Laurie Thompson, who we had called, was not here when we called her. She arrived shortly after.

Barbara Sproll, next on your list, has agreed to switch places with Laurie Thompson.

So, Barbara Sproll would drop to the bottom and Laurie Thompson would present now.

Is that agreeable with the committee?

An Honourable Member: Agreed.

Madam Chairperson: So I'd invite Laurie Thompson from the Manitoba Institute for Patient Safety to present.

Ms. Laurie Thompson (Manitoba Institute for Patient Safety): Thank you very much.

I am the late Laurie Thompson, executive director of the Manitoba Institute for Patient Safety, and I apologize for being late. And I thank you for adjusting your schedule and particularly to Barb Sproll for allowing me to swap places with her.

On behalf of the board of directors, Manitoba Institute for Patient Safety, I am pleased to provide comments and recommendations on Bill 18.

For those who are not familiar with our organization, the institute is a not-for-profit corporation with a mandate to undertake activities to stimulate and co-ordinate the efforts of others and to provide independent and objective advice to all parts of the health-care system in support of minimizing preventable injury to patients.

We are governed by a 12-member board of directors, five who are appointed by the Minister of Health (Ms. Oswald) and seven who are elected by member organizations, of which we have 31, and our current board chair is Mr. Reg Toews.

Our board is composed of the leads of two regulated health professions, five public members, two of whom are former senior health service managers, four practising health-care providers and a government representative. And no board member represents their organization.

So why do we exist? There are many, many dedicated individuals and organizations currently addressing different aspects of patient safety, including regulatory bodies who are the focus of the legislation in question.

However, preventable events causing harm to patients are still too frequent in the health-care system. The system involves multiple organizations and health-care providers, difficult problems of co-ordination and integration of service delivery, the interaction between technology and human factors, entrenched professional cultures which fear open discussion of adverse events and limits to our knowledge of how to best ensure safe, quality health care.

The institute was established to address the complicated issues of patient safety from a system-wide approach and to promote improvement in all parts of the system. We've not yet released our 2008-09 annual reports. I've included in the package a copy of our '07-08 summarized annual report, but I'd be pleased to answer any questions in relation to the initiatives listed.

Improving patient safety will take efforts on many fronts, such as education of health-care providers, building strong and visionary leaders and efforts to make it hard to make a mistake, such as better labelling of drug packaging.

Legislation is also a key foundational mechanism to set the stage for how the health system must put public safety as a priority.

The foundation of the health professions act is protection of the public interest which is obviously supported by our institute.

However, it's important that legislation go beyond articulating what regulatory bodies can and cannot do with regard to regulating their members.

The legislation must also speak to transparency of processes, accountability for actions and principles of a just culture.

It is common to hear the public offer great respect for health-care providers and for their service to the public. Members of the public can also be somewhat sceptical about the concept of self-regulation. At times, there's a perception that self-regulation means self-protection. This perception does not lend itself well to the public's confidence in the system when things go right and, in particular, when things go wrong and patients are harmed.

Systems that strive to develop and improve their culture of safety do so with a foundation of transparency, accountability and a just culture. And these principles not only serve members of regulatory bodies, they also provide a basis for a better informed and engaged public and will help to demystify processes of member regulation.

Our submission provides examples of where Bill 18 is consistent with these principles and where the institute feels the bill can be improved. And we want to emphasize that in the vast majority of cases, adverse events occur in a health-care system, not because of malicious providers, but because of a complex combination of humans working in an imperfect system. Errors will occur because we are human and this does not in any way absolve a providers responsibility for their actions. Quite the contrary. In a just culture, expectations for behaviour are clear as are processes that will take place when patients are harmed.

Regulatory bodies obviously pay–play a pivotal role in having the authority to set expectations for behaviour and approve processes that will be used to protect the public and to address members and the public when patients are harmed. A just culture means that the system has mechanisms in place to ensure fair processes both for providers and for the public, both proactively to help promote patient safety, and reactively when things go wrong.

Our comments and recommendations on Bill 18 are in the context of supporting safety and transparency for the public, fairness for providers and authority for regulators. We support the creation of the umbrella legislation that builds consistency across regulated health professions and see it as an important step in solidifying the public's and the system's expectations concerning self-regulation.

And I'll outline some areas that are particularly consistent with the principles I noted earlier. The best example of promoting public trust is that the council members must take an oath of office that stipulates they are working in the public interest and this act of self-declaration is significant. The reserved act approach is supported as a way to clearly define what procedures present a verifiable risk to patients unless they're in need of restriction and regulation.

Consistency and expectations across regulatory bodies is made possible through the requirement the colleges develop and publicly communicates standards of practice, code of ethics, practice directions and continuing competency programs. Regulatory bodies are, therefore, held to the same standard when it comes to these foundational areas.

The entitlement for all colleges to be able to conduct practice audits is an excellent message and this practice can contribute to learning and improving, which is a key patient-safety principle. The requirement that a third of college members be public members is an excellent start to bringing the voice of people to tables where their experiences as patients and family members can influence policy and practice of providers. And finally, the power of the advisory committee to hold public meetings is supported in an effort to cast a broad opportunity for public input into shaping ministerial advice.

Further details of areas of support are outlined in appendix 1. With regard to areas for improvement, I'll not be speaking in detail to our recommendations. They are included in appendix 1 and it's rather lengthy. But I would like to just, for purposes of the presentation, highlight one area in particular where we feel the bill fails to live up to its objective of serving the public interest.

We do have grave concerns that pharmacy is not included in the modern and uniformed legislation proposed in Bill 18. Effectively, the College of Pharmacy will be without the appropriate tools to govern their members, leaving a huge gap in addressing the best interest of the public and the interest of patient safety. All other colleges councils will have a mandate to set regulations, standards of practice, continuing competency and codes of ethics. And with respect to pharmacists, these foundational elements of self-governance are left to pharmacists to determine.

If it difficult not only to–not only how to imagine not only how the college will carry out it's mandate, but exactly what their mandate is. If it is not having the authority to set out these essential components of public safety, such as standards of practice that regulate the quality of the practice of its members and the ethical principles to which members must abide. The institute feels that leaving these components to members undermines the very essence of addressing the public interest. Of course, we assume that members are setting the public interest first and I'm not suggesting otherwise. However, it is theoretically possible that individual members can override the decision of the council, including the public members on that council, and that is contrary to the principles on which the bill was developed.

***** (21:50)

The institute strongly recommends that the College of Pharmacy have the same authority as that which is proposed in Bill 18 for all other colleges, and recommends that the appropriate sections being 210, 211(1) and (3) be deleted.

In summary, Bill 18 has excellent intentions and the recommendations noted herein, and particularly the recommendation concerning the College of Pharmacy, will help to strengthen the bill and are consistent with building transparency, fairness and appropriate levels of authority for regulatory bodies. Thank you very much.

Madam Chairperson: Thank you, Ms. Thompson.

Ms. Oswald: Yes, thank you, Ms. Thompson. Better late than never, as they say. This is a fine presentation. Thank you for being here.

Madam Chairperson: Thank you very much. Next, call Annette Osted, College of Registered Psychiatric Nurses of Manitoba.

Floor Comment: I'm sorry, did you want the person who switched places with Ms. Thompson?

Madam Chairperson: No. That wasn't my understanding.

Floor Comment: Oh. Then that's fine.

Madam Chairperson: Yes. You can proceed whenever you're ready.

Ms. Annette Osted (College of Registered Psychiatric Nurses of Manitoba): Good evening, and thank you very much for the opportunity to comment on this piece of legislation. I guess I've been around a long time, and have worked with the legislative unit three times for–with legislation in 1980, in 2000, and again this year, so each time it gets better and easier.

The College of Registered Psychiatric Nurses of Manitoba is a regulatory body for the largest single group of mental health professionals in Manitoba. There are about 1,000 registrants who hold practising status pursuant to The Registered Psychiatric Nurses Act.

Psychiatric nursing education programs were first established in Manitoba in 1921, with the first legislation being proclaimed in 1960, and the practice of registered psychiatric nurses is as diverse as the settings in which they practise. The goal of registered psychiatric nurses is to assist people who have mental health problems or illnesses in their journey of recovery. We are fully cognizant of the relationship between mental and physical health, and our responsibility as a regulated health profession is to all vulnerable persons but especially those whose vulnerability is due to emotional, mental, or developmental issues.

The Mental Health Commission of Canada is currently in the process of developing national mental health strategy for Canada, the only G8 country without such a strategy. There's finally recognition of the individual, societal, and economic impact of mental illness and emotional difficulties in our country.

Businesses are taking more action to assist their employees to remain mentally healthy. That, in turn, helps those same employees to remain more physically healthy, thus decreasing overall health-care costs. We are just now starting to gather the data that will give us hard evidence of the value of investing in the mental health of our citizens no matter what social or ethnic group to which they may belong and no matter what their geographical area of residence.

Within the context of the national mental health strategy, the issue of human resources is being reviewed. There is an assumption that the only effective way to deliver mental health services is through collaboration between service providers and those living through a mental health problem and their families and especially between the different health service providers themselves. Collaboration can only happen between entities who are partners in an effort, and partnership include a full

understanding of each other's roles and responsibilities.

Manitoba is also in the process of developing a mental health strategy. We therefore see the development of a regulated health professions act as timely. This legislation establishes common criteria for the regulation of health professions who are partners in the delivery of health services in the province. We hope that the legislation will provide for a better understanding on the part of the public of the role of a regulatory body for a health profession.

We also support the proposed legislation because it provides a framework for collaborative practice. Wherever health services are provided, collaboration between health professionals with different and complementary expertise is necessary to ensure effective as well as efficient services. The primary reason for the regulation of health professions is to ensure that persons who require services from health professions are protected from incompetence and/or unprofessional behaviour.

This frame of reference is critical to ensure that this raison d'être is not only acknowledged, but that it is actualized consistently by the regulatory body. We understand that the Legislature delegates this responsibility to the regulatory body and that there's no room for deviation from this mandate.

The Regulated Health Professions Act will assist us all in ensuring that the welfare of the public continues to be at the forefront of our concern as systems change and roles evolve. We also appreciate the continued inclusion of public representatives on various bodies of the regulatory body as part of the checks and balances to ensure that the regulatory body is not in a conflict of interest position between some of the needs of its registrants and the needs of the public.

Given the above context, we do wonder why it is proposed that the college of pharmacists not have the same clear mandate as all other regulated health professions. We anticipate that evolving roles for registered psychiatric nurses will require even closer collaboration with pharmacists in the province, and consistency in the role and processes of all regulatory bodies would be useful.

In summary, the College of Registered Psychiatric Nurses of Manitoba supports The Regulated Health Professions Act. We believe that it will facilitate the continued evolution of roles and partnerships in the delivery of all health-care services of Manitoba. We also would like to thank the staff of Manitoba Health and Healthy Living who were of great assistance in facilitating the participation of all regulated health professions in the development of this legislation.

We also want to mention their patience with some of us who did not always have the resources to meet all deadlines, but they were very generous with their time, and we thank them and you, Madam Minister, as well.

Madam Chairperson: Thank you, Ms. Osted.

Ms. Oswald: Yes, thank you, Ms. Osted, for being here tonight, for taking the time to thank the hardworking staff at Manitoba Health. This has been a labour of love. I think they'd refer to it as labour in the, you know, true baby-delivery sense and–but I really appreciate your good counsel, your advice tonight and thank you for being here so late in the evening.

Madam Chairperson: Thank you. Seeing no other questions, thank you for your presentation.

I'm just going to ask the committee, we had agreed to re-evaluate at 10 o'clock and it's coming up on 10 so what is their advice?

Mr. Doug Martindale (Burrows): Madam Chairperson, we're making good headway here through this list, especially when some people don't use up all their time and I would recommend that we sit till 11.

Madam Chairperson: Okay. There's a recommendation that we sit till 11. Is the committee agreeable to sit until 11?

Some Honourable Members: Agreed.

Madam Chairperson: Agreed. We will continue to work our way through this list.

Next on my list I have Laureen Lipinski. Welcome, Ms. Lipinski. Do you have a written presentation?

Ms. Laureen Lipinski (Private Citizen): No, I don't.

Madam Chairperson: Okay. You may proceed whenever you're ready.

Ms. Lipinski: Madam Chairman, minister and committee members, thank you for making this time available for me to speak with you today.

My name is Laureen Lipinski. I have lived in Manitoba all my life, born, raised and educated here. I am here today as a private Manitoba citizen. As background, so that you can understand the basis of what I am to share with you today, I have been a licensed pharmacist in Manitoba for 27 years.

I worked for a number of years in hospital pharmacy at the Health Sciences Centre in a variety of positions, including practising in all three ICUs, intensive care units, adult, pediatric and neonatal. As a clinician on an adult medical ward, I managed the Pharmacare exception drug status line as the position was seconded to the Health Sciences Centre at the time, and I managed two large drug-use evaluation projects, one of which was conducted in nine Manitoba hospitals.

***** (22:00)

After this I left hospital pharmacy and worked for a number of years in retail pharmacy, both as a staff community pharmacist and a corporate resource for a large national drugstore chain. As a corporate resource, I was accountable for the pharmacy operations in 28 Manitoba stores and six stores in Ontario.

I am currently a regional pharmacy manager with the Winnipeg Regional Health Authority, where a large part of my time is spent in implementing and managing the contracts for pharmaceuticals in virtually all the hospitals in Manitoba. I continue to work in community pharmacy one evening a week.

The health professions act is very important and exciting time for enhanced patient care and safety, the health professions and the governing councils. This legislation includes important sections such as reserved acts which can be performed by qualified health-care professionals and the very clear public protection mandate of all the college's council.

One notable exception was made for the practice of pharmacy under the health professions act is the manner in which the regulations and the code of ethics are approved. For all other health-care professions in Manitoba, the governing council has the authority to approve regulations after consultation with the members and consideration of the comments and feedback.

Interestingly, with the exception of New Brunswick due to their unique legislative structure, Manitoba is the only regulatory body in Canada that has pharmacy members approve regulations. The council for the college of pharmacists will not, under the new act, have this authority for the approval of regulations of the code of ethics. The reasons for this exception have not been clearly stated, however, anecdotally, it is understood that the government has chosen to make this exception because the commercial aspect to our industry means pharmacists are different from other health-care providers.

The rationale for entrusting the ability to pass regulations through the reg–regulatory authority is to ensure that decisions regarding the protection of the public are made by an elected and accountable body. It is my opinion that the pharmacy should be treated–that pharmacy should be treated no differently than any of the other 22 health professional groups that this act would govern.

Has the Mani–has the government of Manitoba consulted the Moving Forward, Pharmacy Human Resources for the Future, a national study that received $1.5 million in funding from the Canadian government to look at how the use of pharmacy human resources could be maximized so that, in the future, we will have the right health-care professional in the right place at the right time, providing the health services that are needed to optimize the health care of Canadians as part of their due diligence before making such a notable exception.

Is it realized by the government of Manitoba that many of the changes recommended in this document, such as expanded roles for pharmacy technicians, greater use of automated drug distribution technologies and expanded roles for pharmacists have not been to move ahead in this province due to the impasse in passing regulations to the pharmacy act of 2006, and that such an impasse is unlikely to resolve with pharmacy being an exception to the health professions act?

Has the government of Manitoba made itself aware of the changes other provinces have made to the practice of pharmacy in response to the Moving Forward document?

Pharmacists are prescribing in the province of Alberta, and Ontario is moving forward with implementing a new structure to regulate pharmacy technicians in their expanded roles. Many other significant changes in this regard are, are occurring in most other provinces at varying stages of, of development. These changes can only have gone forward with the appropriate regulations in place.

Is the Manitoba government aware that the practice of pharmacy in Manitoba has fallen behind and continues to fall behind in many other provinces of Canada?

From my point of view, this act held out the promise of a new framework within which the profession of pharmacy in Manitoba could move forward, particularly with respect to overcoming the impasse that has prevented the passage of regulations to the pharmacy act of 2006. Would not such an impasse indicate that the profession of pharmacy would be well served by allowing elected council, with membership consultation, to pass regulations.

I support the principles in which the health professions act is based. Professions must act in the best interest of the public, not their own self interest. Members of the profession must play an active role in the regulation of their own profession. Members of the public, who are not members of the profession, need to have a significant say in the affairs of all professions to ensure the act in public interest. Health professions should have a common regulatory framework that allows their members to practise to the fullest extent.

Please consider the single exception of pharmacy and include them with the other 22 health professional groups where the governing council has the authority to approve regulations after consultation with the members and consideration of comments and feedback. Thank you.

Madam Chairperson: Thank you, Ms. Lipinski.

Ms. Oswald: Yes, thank you, Ms. Lipinski, for being here so late at night to give your point of view. It's a very strong argument for, for one side and I respect that. And I want to assure you that, certainly, we are paying very close attention to the development of professions and their practice, pharmacy specifically, in other jurisdictions, and so I appreciate your comments related to that, the Moving Forward document and the climate that we have here in Manitoba at present. Thank you for being here tonight.

Mrs. Driedger: Thank you, Ms. Lipinski.

I have a question related to pharmacy technicians. Can you explain to me what their role is and how significantly are they used in hospitals as well as in the community?

Ms. Lipinski: Well, they're used–

Madam Chairperson: Oh, sorry, Ms. Lipinski.

Ms. Lipinski: Thank you. They're used vastly in both areas. In, in community pharmacy it depends more on the, the level of business. I guess the same would apply, but in hospitals you generally have a certain population that's somewhat guaranteed, whereas if you open a, a new store, you're not going to have a–you're going to start at a zero prescription base and then you're going to work your way up to, you know, as high as you possibly could.

So in, in a hospital, technicians are more of a stable base, whereas in a community it might vary a little bit more about how much technical support you might have.

Madam Chairperson: Thank you, Ms. Lipinski. Thank you for your presentation.

Ms. Lipinski: Thank you.

Madam Chairperson: Next on the list we have Kevin Hall. I understand he wasn't able to be here tonight. He's requested that Colette Raymond read his presentation in his place. Is that agreeable to the committee?

An Honourable Member: Agreed.

Madam Chairperson: Go ahead, Ms. Raymond.

Ms. Colette Raymond (Private Citizen): Thank you. Madam Chair, Madam Minister, honourable members, ladies and gentlemen. My name is Colette Raymond and I am a clinical pharmacist. I will be speaking today on behalf of Dr. Kevin Hall.

Thank you for the opportunity to provide input to the members of this committee as they prepare, consider the proposed health professions act.

Kevin Hall's comments to the committee are being provided as a private citizen; however, his work and involvement in several national pharmacy initiatives serve as the background on which his comments are based.

Namely, for the past 11 years, Dr. Hall has served as the director of pharmacy for one of Manitoba's regional health authorities. For three years Dr. Hall co-chaired a national pharmacy human resources study, which we just referred to, called Moving Forward: Pharmacy Human Resources for the Future; and, thirdly, in 2008 and '09, Dr. Hall served as a member of the human resources work group for a national pharmacy initiative that builds on the work of Moving Forward.

This initiative, called Blueprint for Pharmacy, has led to the development of an implementation

plan for a new national vision for pharmacy: optimal drug therapy outcomes for Canadians through patient-centred care. The blueprint is based on the belief that if pharmacy is to deliver the promise of optimizing drug therapy for Canadians–which we heard a little bit about earlier this evening–the profession will need to change its focus from a commercial and product-centred one to a professional and patient-centred one. To achieve this there will need to be significant changes in the practice of pharmacy, including substantial changes to the role of pharmacists and pharmacy technicians. This blueprint has been endorsed by all of the provincial regulatory authorities in Canada, 19 national pharmacy organizations that represent members of the profession, all of the faculties of pharmacy, 19 of the largest drugstore chains in the country, and many individual pharmacists. While changes in the blueprint implementation plan may be threatening to some members of the profession, they are the right changes from the public interest perspective.

Within our health region we have almost completed a two-and-a-half year plan to implement the pharmacy practice changes recommended by these important documents, Moving Forward and Blueprint for Pharmacy. However, we are now stalled at the final stage of implementing these changes because the new regulatory framework that would have enabled these changes has, unfortunately, not materialized.

Why has the new regulatory framework not materialized? A new pharmacy act was passed by this Legislature a number of years ago, an act that would have provided a new regulatory framework for pharmacy, including several key provisions. First, provisions that allowed for an expanded role for pharmacy technicians so they could assume more responsibility for technical drug distribution activities that unnecessarily consume a great deal of many pharmacists' time.

Second, provisions that allow for greater use of automated dispensing technologies that are safer, more efficient and less costly than archaic manual processes that are used in many pharmacies.

***** (22:10)

Third, provisions that allow for expanded roles for pharmacists in the management of medication, a role for which they are well-trained but poorly utilized because they are currently required to carry out many technical drug distribution activities that can be better done by technicians and technology.

Fourth, provisions that allow pharmacists to adjust drug therapy and independently prescribe under certain circumstances, similar to the prescribing rights granted to nurses in their most recent legislation. Prescribing rights for pharmacists would enable better access to drug therapy, particular for chronic illnesses, which would possibly, in turn, help free up pri–primary care physicians here in Manitoba.

These changes in the regulatory framework would have allowed pharmacy in Manitoba to begin catching up with the changes in pharmacy practice that many other provinces ha–have already implemented.

Why hasn't the profession been able to move ahead with these progressive changes? The impasse was created by a last-minute decision by the Legislature to amend the pharmacy legislation and allow pharmacists the right to vote on their regulations. The pharmacist members–as you've heard many times–subsequently defeated the draft regulations developed by their council, which includes lay representatives, and the different pharmacy factions have not been able to agree on a revised set of regulations that satisfy both self-interest and public interest. As a result, the pharmacy act has not been proclaimed and the profession has not been able to move forward with the changes as that–that other provinces had already made.

So what does this have to do with the health professions act? Dr. Hall wants to make it clear that in almost all respects, the proposed health professions act is based on sound principles that support the implementation of the needed changes in pharmacy practice. From his perspective, the health profession act held out the promise of a new framework within which the profession of pharmacy could move forward to achieve the new national vision for pharmacy.

It's clear that the general membership of any profession may have difficulty in separating self-interest from public interest. In recognition of that potential conflict, the original draft of the health professions act followed the lead of other provinces that have similar legislation and did not permit the individual members of any profession to have the final say on their regulations developed by council.

Dr. Hall believes that this change would eventually allow the profession of pharmacy in Manitoba to escape this gridlock that we're in and move forward with progressive changes that other provinces have introduced. These changes include the Ontario initiative to expand the scope of practice and regulate pharmacy technicians, an initiative that is now coming into effect after 10 years of preparatory work. The new scope of practice in pharmacy technicians will allow them to assume much of the technical drug distribution role that is now done by pharmacists.

Manitoba has made no significant process in this area.

In Alberta, pharmacists are assuming new direct patient care responsibility, particularly prescribing responsibilities, and are applying their patient care skills to the management of chronic diseases. Because of the delay in the pharmacists' passage of the regulations to the pharmacy act, Bill 41, pharmacists in Manitoba cannot move forward with similar chronic disease management initiatives or many other patient-focussed initiatives that other provinces have taken.

However, even if the health professions act is applied to pharmacy, pharmacists will retain the right to vote on their regulations for some years to come. Any change in that regard would not come into effect for a number of years because of the voting rights given to pharmacists in the most recent pharmacy act. These voting rights would remain in effect until pharmacy was eventually rolled under the health professions act. Although this would still leave Manitoba pharmacy far behind the progressive changes in pharmacy practice in other provinces, it would, perhaps, salvage the shipwreck that pharmacy in Manitoba would otherwise become.

Dr. Hall was very surprised and disappointed to learn that a last-minute change was again made in the health professions legislation, a change that affects pharmacy alone. The changes would permit pharmacists–and only pharmacists–to continue to vote on their regulations, and no other profession was granted a similar exemption.

The reasons for the exemption have not been explicitly stated, but it appears that pharmacy, unlike other professions, is viewed as one where the self-interests of its members–whether these be commercial interests, fear of job security, fear of change or any other self-interests–must be allowed to have the final say in the governance of the pharmacy profession. These short-terms, self-interest goals will adversely affect the profession of pharmacy to achieve its full potential in improving drug therapy outcomes for citizens of this province.

Although many other provinces have leg– legislation similar to the draft health professions act being considered by this Legislature–legislation on which the members of the health professions do not have the right to vote on regulations prepared by a council that includes lay representation–none of these provinces have made an exception for pharmacy. What justification can there be for a decision that has been made in Manitoba?

The preamble to the health professions act states that the legislation's intended to create a common regulatory framework for all health professions. Is pharmacy not a health profession?

The self-interest group that represents many of the pharmacists in Manitoba has made its case, and they cannot be blamed for doing so. It is this Legislature, however, that has the responsibility to ensure that the health professions act applies to all professions that are supposed to act in the best interest of the citizens of Manitoba, not their own self-interest. Legislation that would enable pharmacy, and pharmacy alone, to be exempt from a common regulatory framework that is intended to ensure the public interest is paramount cannot be justified.

Please ensure that pharmacy is able to move forward with progressive changes that serve the public interest. Please treat pharmacy, first and foremost, as an important health profession. Remove the exemption that allows pharmacists to vote on a– regulations developed by the council of the college of pharmacists. Enable pharmacy in Manitoba to fulfil the vision for the Blueprint for Pharmacy and moving forward, that is, optimal drug therapy outcomes for Canadians through patient-centred care.

Thank you for allowing me to present on behalf of Kevin, who is at the Canadian Pharmacists' Association in Halifax right now.

Madam Chairperson: Thank you very much, Ms. Raymond. Seeing–oh, Mrs. Driedger.

Mrs. Driedger: I have a question related to pharmacy technicians, and my question relates to the fact that the new pharmacy act–I guess it was Bill 41–included provisions that allowed for an expanded role for pharmacy technicians. Can you

explain what that expanded role would be for pharmacy technicians?

Ms. Raymond: Thanks. Thank you. I can. The expanded role for pharmacy technicians would be doing technical functions within a pharmacy. So I've only ever worked in a hospital pharmacy. Experience with technicians in a hospital pharmacy shows that technicians select the product that is appropriate for the prescription and make sure that it's what has been inputted into the computer, make sure that it's the right drug for the right patient. Pharmacy technicians all have–also have a very important role in preparing sterile products within a hospital pharmacy, and they're also involved in the checks of those products, meaning that they check to make sure that it's the right drug that's being dispensed and it's the right drug that matches the prescription. They're also very important in checking per–prepackaging. We would like to hope that everything comes as we want it to come from the pharmaceutical manufacturers; unfortunately, that's not the case. We need to repackage, and pharmacy technicians spend a great amount of time repackaging things into unit dose drug distribution system and they play a very important role in checking, again, to make sure that it's the right drug, it's labelled appropriately, et cetera. So they are a very, very important role for technical act–aspects of drug distribution.

Mrs. Driedger: Is their role being compromised in any way by this legislation, you know, not being passed the way it is, or by Bill 41? Like, is there some concern around the role of pharmacy technicians?

Ms. Raymond: I think the concern is that the role of the pharmacy technicians is not allowed to expand as it is–it could otherwise. We still now require pharmacists to check an awful lot of things. Pharmacists do spend an awful lot of time doing technical activities of drug distributions, which, under the new legislation, could be undertaken–more safely and effectively than by pharmacists–by pharmacy technicians. So, yes, in the fact that their role would not be optimized.

Mrs. Driedger: Can pharmacy technicians do any patient teaching?

Ms. Raymond: I don't believe it's against the law. I think that in many places, in Ontario, for example, pharmacy technicians do interact with patients. I receive pharmacy journals, and there's a column called "Tech Talk" where there's often aspects about patients, interactions and patient care. So I believe in many provinces, this exists. In Ontario, certainly.

***** (22:20)

Madam Chairperson: Thank you very much. Seeing no further questions, thank you for your presentation.

Next, I would call on Pat Trozzo. Pat Trozzo. Is Pat here? Okay, Pat Trozzo drops to the bottom of the list.

Next, Penny Murray. Welcome, Ms. Murray. You can start whenever you're ready.

Ms. Penny Murray (Private Citizen): Thank you. Thank you very much, Madam Chair, ministers, mem–honourable members.

I really appreciate the opportunity to be able to present to you this evening. I would like to share with you first my background. I am an individual pharmacist presenting tonight. I graduated 60 years ag–pardon me, not 60 years ago, 40 years ago in 1969, and because of that, I've had a long and varied career. I've practised in retail pharmacy with independent stores, with retail stores that are chain. I've practised also as a relief pharmacist. I've also practised in hospital and, most currently, am practising as a long-term care pharmacist with the Winnipeg Regional Health Authority, although I did work as a consultant pharmacist in long-term care with a community pharmacy.

I also want to share with you that I've had extensive involvement in the numerous committees required for a self-governing profession. I've chaired professional development. I have been a member of professional relations. I have chaired the complaints. I have chaired discipline. I have chaired the standards of practice for long-term care, and I have been a member of council and MPhA executive. I've belonged to MSP. I've also–currently belonging to CSHP, both of whom presented tonight. I'm also a member of our national organization, CPhA, and I have held executive positions with the Manitoba Association of Pharmacy directors and also with an international organization called the Canadian Society of Consultant Pharmacists.

I do want to share with you that in my belief there is a dangerous inequity, which exists in an otherwise excellent Bill 18, The Regulated Health Professions Act. No other health profession under this umbrella act is singled out in this manner, and that is the exception that provides the pharmacists of

Manitoba with the right to vote on regulations to their act prior to presentation to the government. And this bill also requires pharmacists to vote and approve their standards of practice, to provide a final approval on the code of ethics and on issues of continuing competency, whereas for every other profession there must be consultation and consideration but the final decisions on matters forwarded to government rests with the regulated council. I urge you to move an amendment to ensure that all health professionals in Manitoba are governed by consistent, uniform regulations with an enhanced focus on patient safety and accountability. The health professions act, section 210, 211(1), and 211(3) must be amended to delete the single exception made for the profession of pharmacy.

In the spring of 2007, I had the honour of addressing the graduating students into the profession of pharmacy, and at that time I said that pharmacy is a health profession. It's a caring profession. It's a helping profession. And, by the spring of 2007, I'd experienced several years on council and, perhaps like you in public service, many ups and downs. Yet I was optimistic that our Bill 41 would be pass–that was passed in December of 2006–would be proclaimed soon with regulations that would permit the growth and expansion that I alluded to when I addressed those students. This belief sustained me, despite an unexpected amendment initiated by the Liberal Party, which occurred on the third reading and provided the right to vote for pharmacists. Yet, today in June of 2009, Bill 41, The Pharmaceutical Act, has not yet been proclaimed almost three years later, and this, despite numerous town hall meetings, numerous district meetings, surveys and the circulation of draft discussion documents to ensure consultation with membership.

I've always understood that the cornerstone for the vision, mission and values of the MPhA is public safety, and, in fact, our mission states that we are there to protect the health and well-being of the public by ensuring and promoting safe, effective and progressive pharmacy practice. Council must ensure that pharmacists within the profession practise in a manner that safeguards the public and the public interest through effective and progressive practice, and, generally, most pharmacists do. Laws and regulations, policies and rules are established because most is not all.

Does the average pharmacist want the vote? Probably. You heard tonight 93 percent of the survey said they did. Even though many do not exercise their right–but it's human nature to avoid change, to hold closely what you have and know. To confuse having a vote with democracy and rights, to be required to give up what has been yours may be frightening. We as pharmacists have the vote. We have the right to the vote, but not the obligation to vote and not to understand the issues that are brought before us. And those issues can be very complicated. In fact, there are examples where pharmacists do sometimes allow self-interest to win over public safety. I hesitate to, to discuss this, but issues of self-interest, issues of business, issues of-self doubt, all of them impact on the individual pharmacist and how they vote.

As examples, I'm going to mention and talk about continuing competence. I'd like to discuss our current draft regulations and perhaps particular issues that have hit the public like tobacco or inducements. Continuing competence must be a major concern for all professions as new knowledge grows exponentially. It has been said that a graduate's knowledge is obsolete after five years, and if a profession is self regulating, we must attempt to ensure that our members are current and capable. And, in today's world, it needs to be documented.

A learning portfolio process was presented. It was adapted from Alberta and Ontario where it was in place. And, subsequently, the portfolios that MPhA offered was adopted by the College of Registered Nurses of Manitoba. Our members–the feedback provided was it takes too much time. There's too much documentation. It's too much trouble, and they voted it down.

Inducements and tobacco are business practices that are extremely difficult to defend as an appropriate health-care activity, and extremely difficult to change given the arguments that these are business practices and not within the purview of council. The regulations to Bill 41, The Pharmaceutical Act, haven't been passed yet. They were voted on and they were defeated. The act is enabling and exciting and would have established Manitoba pharmacists as leaders in the nation, but pharmacists defeated it. When asked why, and I asked them, some said, I can't; some said their employer told them to vote no. Others indicated that too much documentation and recordkeeping was required. Others were concerned that, with all the changes, their ability to work might be compromised. They were threatened by proposed changes that would move their more mechanical responsibilities

to trained technicians and allow them increased patient contact–increased patient contact to combat the adverse drug problems that statistics show us contribute to numerous hospital admissions and death.

Emotion from the current council shortly after Bill 18 was released was forwarded to the government. Interestingly, neither mover nor seconder of the motion put forward by council in response to the change are elected members of council. One is a lay member appointed by this government with experience in the bureaucracy of government, and the other is the dean of pharmacy charged with the education of students of pharmacy. In addition, the drafters of Bill 18 have worked closely with knowledgeable administrators from each profession included in the regulated health professions. Pharmacy was no different, and the requirements regarding regulations were consistent until two days before the first reading of Bill 18.

Why are pharmacists an exception to the process for the development of regulations, the development of standards of practice, of the codes of ethics, of continuing competency? Why does the Government of Manitoba feel that pharmacy in Manitoba is vastly different than pharmacy in British Columbia or Alberta or Saskatchewan or Ontario or Québec or Newfoundland or Nova Scotia or Prince Edward Island? Is it any less of a business in those provinces?

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Madam Chairperson: I'm sorry to interrupt you. You have 30 seconds remaining.

Ms. Murray:–and why does this government feel that the business of pharmacy is different from the business of dentistry or medicine or optometry or physiotherapy? In fact, so different that several other health professions, including physiotherapy were denied the right to vote, even though the right to vote had been part of their self-regulatory authority.

I know that we have to make tough decisions. No new council member can honestly sign the oath required by Bill 18. The increase in public representation is deluded. I urge the committee to amend Bill 18, deleting the clause related to the exception for the profession of pharmacy. I thank you for your attention.

Ms. Oswald: Yes, thank you, Ms. Murray, for being here late into the evening to present your point of view on this issue. I was very interested in what you had to say about the issue of continuing competencies, and I wonder if you could offer a perspective. You know, from your point of view, are those pharmacists employed in retail environments not doing professional development or not working to maintain current competencies, you know, as things stand today?

Ms. Murray: I believe that pharmacy's been very proactive in ensuring continuing competency within our profession, and we have certainly required what we would call continuing education units and have done so for many, many years–since the early '70s.

As we move forward with the further understanding of exactly what is meant by competence, we recognized that attending a lecture or an in-service and accumulating points is not necessarily a full measure of competence. When we tried to establish a learning portfolio, what we were looking for was saying to individuals you are responsible for your own learning. You need to, to determine what it is that's important to you, what is missing from your knowledge and pursue that. Pharmacists told us they didn't want that openness. They wanted, they wanted more direction and more specificity, and they didn't want to do that self-reflection that was required. And that's what they found difficult, and that's what they felt that they did not want to do.

Ms. Oswald: Well, it's the age-old argument about portfolio evaluation. I remember from my other life. You know, just give me the test, teacher. Don't make me do that kind of, you know, more broad, self-reflective. Just let me fill in the answers, and so I understand the point that you're making. But, just to clarify, would you say that in terms of measuring, you know, continuous professional development, you know, continuous competencies, you know, continuous learning required in the health professions specifically related to pharmacy that, as a rule, hospital pharmacists are more proficient at that than pharmacists in a retail environment? Would you say that that is so?

Floor Comment: I would say–

Madam Chairperson: Ms. Murray.

Ms. Murray: Pardon me. I would say that hospital pharmacists, perhaps, have many more opportunities to pursue that within their work life, and, certainly, as a retail pharmacist, I know that my opportunities have been in the evening, on my own time or reading journals or pursuing more self-directed learning. But

I would say to you that I've–I truly feel that pharmacists recognize the need for that maintenance of education and look for opportunities to do so. Is there a difference between hospital and retail? I don't think there's a difference in motive or intent.

Mr. Gerrard: Thank you for your presentation. One of the things that we, we've heard from various people earlier tonight about the difference in terms of the technical nature and the role of technicians, the importance from cutting edge in terms of the need for pharmacists to become more involved with patients, but decisions about drug usage, and is this where the divide is, in terms of where–you talked about self-interest and the people don't want to put in the extra work, as it were–I mean, I'm just trying to sort of come to grips with critical divisions which have, you know, not enabled the regulations to pass and, and how they can be addressed.

Ms. Murray: It's a complicated question, and I think much of it might have to do with, with the confidence of an older pharmacist in a change in the way they practise pharmacy. Many people are happy with the process that they have in place right now. If a technician frees them up from doing the mechanical checking, then what am I supposed to do? And so the answer of perhaps spending more time with you as a customer or a patient and, and delving more into your–the medication management that you have and that's required is, is part of this situation. A younger pharmacist, the pharmacist that Colleen is teaching right now, are trained to do that.

When I graduated in 1969, I wasn't allowed to tell an individual what the drug was that they were taking, so, yeah, I couldn't tell you what drug you were taking; you had to tell–ask the doctor. So the changes have been exponential and technicians have, have recently come more to the fore. There is more training; they're, they're more intensely trained. They have a very broad degree of training and they are looking at looking after, specifically, the distribution to free up the individual pharmacist. The challenge there is, will my boss allow me to do that? And, in retail, can we continue to make money if we do that?

Madam Chairperson: Thank you, Ms. Murray. The time for questions has expired. Thank you for your presentation.

Next, I would like to call on Heather Milan.

Thank you. Welcome, please proceed when you're ready.

Ms. Heather Milan (Private Citizen): Good evening, honourable minister, committee members and other people that are attending this meeting. I'm Heather Milan and I appreciate this opportunity to present to the committee as a private citizen.

I support Bill 18, The Regulated Health Professions Act, in–with all its overall principles. I think it's really a very unique–not unique, but certainly a very, very important legislation for all of our health professions.

But I do not support the exception proposed for only pharmacy that requires approval of regulations by the membership. I believe that–in clear language–I think it's ill advised and a regressive precedent to be setting in new umbrella–in a new umbrella act going forward.

As, as background, I'm a licensed pharmacist in Manitoba since 1970, and I've worked in the hospital pharmacy sector for 27 years, with 23 of those years as a pharmacy manager. I'm currently a regional manager with the Winnipeg Regional Health Authority, responsible for drug distribution systems. I also, I also worked for 10 years in, in a community health clinic and also have some experience in the retail setting. I speak primarily from my hospital experience.

***** (22:40)

Let me explain a, a little background which has led me to this stated position on Bill 18. In the last 15 years or so, great efforts have been focussed on increasing the clinical role of our pharmacists in direct patient care on the nursing units where they can contribute their knowledge most effectively. That time has been facilitated by minimizing their work in the technical aspects of the drug distribution system. So getting those drugs ready, getting those drugs up to the wards for administration to the patients, that is the drug distribution system.

Some success has been achieved in doing that. We've increased the role of the pharmacy technicians. To some degree, we do have tech-check-tech, too, in a small way in our hospital sites, and what that involves is technicians checking each other for certain technical activities that do not require a professional knowledge and judgment. They are well trained for that role. There's a certification course that they go through that trains them for that checking responsibility, and they have to meet a certain standard before they're allowed to do that. So we have a course within our hospital sector that

trains technicians to check each other and take on that responsibility which they are very pleased to do, and we really rely on the pharmacy technicians in our, in our part of our sector of hospital pharmacy.

We also have increased the use of technologies to support the drug distribution system. You've probably heard of automated dispensing machines or what we use in our region is called Pyxis and that's the company and it–virtually, virtually are vending machines that are placed on the nursing units and they are interfaced with the pharmacy system so that when a pharmacist enters the order, they do the drug order review for the prescription to make sure that the drug dose, all the patient history, the other drugs that they're on is all taken into consideration. They enter the order. The order is transferred electronically to the Pyxis cabinets that are on the nursing unit in the nursing stations. The nurse when she needs the medication for a patient, approaches that cabinet which is full of many different drugs, enters the patient name. The patient profile comes up on a screen. She selects the drug that she needs, and a drawer opens in the cabinet and provides to her the drug that she needs.

So for that type of technology, it's revolutionary for pharmacy practice, and it's revolutionary for nursing practice. And it's really beneficial to both disciplines, and it's well accepted by both. We need pharmacy technicians to run the reports, to gather the drugs, to package all those drugs in unit dose format with the name on each package so every dose is individually labelled. We need them to gather all that, thousands of doses a day, take them up to the Pyxis cabinets and load them for what is required for that cabinet to top up the minimum/maximum levels that are required.

So we have Pyxis machines now at four of our sites, and we have, we have the funding to add three more. So in there and in the next two years we'll have automated dispensing machines on the nursing units at, in all of our acute care facilities. So that, you know, the use of pharmacy technicians and the increased use of technology has allowed us the time to free up the pharmacist to go up onto the nursing units and spend time with the care teams, looking at the patients' needs, the charts, advising on prescriptions, changing prescriptions and adding their knowledge to the care of the patients.

We've done that to a pretty good degree, but we need to do more, and we–the delegation to the pharmacy technicians really is allowed in a very limited way by our old pharmacy act. We were anticipating the new pharmaceutical act, Bill 41–which we've been waiting for for about a decade now, but it was passed in December of 2006–we're waiting for it to be proclaimed so that we can make further strides in advancing the clinical role of the pharmacist. We've been waiting for two and a half years for the membership to agree and approve those new regulations so that we can move forward.

The various reasons for the impasse, for the divisiveness, is something that has been discussed at length here. I'm not going to get into what all the possible reasons are. I think we really have to, we really have to be clear and we have to realize that there are business interests in our profession and sometimes they take precedence over patient care interests or the public interest. That's the, that's the reality of our profession and we have to, we have to get around it and, and work, work at a way of, of coming to agreement on the regulations so we can move forward.

It's–the stalemate's been very disheartening and concerning for those of us practicing in the hospital sector where, again, we have no business interest in the hospital sector. That isn't our, our fault, that's the way it is and we work with it and, and we, we enjoy our jobs whe–with our primary interest being patient, the patient care. That's what, that's what we're there for.

I'm very fearful that progressive changes in hospital practice will be stymied and the fact that we have had a lack of agreement on the new regulations for two and a half years now really substantiates that fear, as, as far as I'm, I'm concerned. Extensive changes in, in the plans for the Winnipeg Regional Health Authority pharmacy program's organization and our pharmacy practice model may be jeopardized.

Madam Chairperson: I'm sorry to interrupt; you have 30 seconds left.

Ms. Milan: So plans for having the pharmacy technicians virtually run our drug distribution systems so that we can get our pharmacists up on the wards, efficiency plans for centralizing drug packaging and IV admixture can't happen as long as we don't have Bill 41 and the regulations in place.

And the relationship with, with Bill 18, which I'm just coming to, is that Bill 18, by having the exception for pharma–pharmacy to have a vote from their membership is really perpetuating the problem

and it's, it's entrenching it in legislation, which really–which I think is, is really a bad, a bad way to go. I don't see pharmacy is, is really dramatically different from the other health-care professions. Other health-care professions have business interests as well as patient care interests–

Madam Chairperson: Thank, thank you, Ms. Milan. Your time has expired.

Questions.

Ms. Oswald: Yes, thank you, Ms. Milan, for being here. I appreciate what you're saying about, you know, we have to acknowledge that business interests exist, and, you know, we're just going to have to carry on and, and deal with that.

I was wondering what you thought of the idea that I presented earlier–that is not mine, it was attributed to me, but I was repeating what had been brought forward to me–and that is that in order to, to treat the profession of pharmacy in the same way that all other professions are being treated–that is to say, once, you know, they become a college–that they, indeed, have the same or very similar mandate as all of the other colleges, and, and perhaps take away part of the mandate that exists now in licensing pharmacies and, and, you know, all of those business-type practices. What would you think of the concept of, of having a college that bore a, a more similar resemblance to nurses and doctors and so forth? And, and note the MPhA, moving forward to the college, no longer had any say in, in the issue of licensing and that would be another body altogether.

***** (22:50)

Ms. Milan: I think that would be good. I think that most of the health–I don't know all the lists, but I think most of the health professions are knowledge professions, and so having a college that oversees the clinical, you know, our clinical knowledge and how we use it and how we manage it would probably be, you know, very advantageous.

I don't know how the, the commercial side or the retail side would be dealt with in terms of the stores, but I think there's a time, I think there's a time with this professions act to really focus on what our professionals are really educated to do, what their knowledge is, and I can't–I have to think about it some more, but I think it's worthwhile pursuing, for sure.

Madam Chairperson: Thank you, Ms. Milan.

I'm going to try and squeeze one more in. Nicholas Honcharik. Is Nicholas Honcharik here? Thank you.

You may proceed, sir.

Mr. Nicholas Honcharik (Private Citizen): Good evening, Madam Chair and committee members. I appreciate the opportunity to present my comments regarding the health professions act.

I'm presenting tonight as a private citizen, and to give some background to my experience in the pharmacy profession, I've been practising as a clinical pharmacist within the hospital sector for the past 31 years in both Canada and the United States. My current positions are a regional pharmacy manager within the WRHA pharmacy program, assistant clinical professor of pharmacy at the Faculty of Pharmacy, University of Manitoba, and also serving as a practising clinical pharmacist in the adult intensive care units at the Health Sciences Centre in Winnipeg.

Overall I commend Manitoba Health for putting forward this model legislation, which has ensured all health professions in Manitoba are governed by consistent, uniform regulations with an enhanced focus on patient safety and accountability, though I do not support the proposed exception for pharmacy members to have the ability to vote on new regulations as stated in section 210 of the health professions act.

The health professions act held the potential of a new, viable framework where the profession of pharmacy could move forward, moving forward particularly in regards to overcoming the gridlock that many of the speakers today have mentioned in regards to the 2006 pharmacy act. The draft regulations, as we've been told, have been developed by the Manitoba Pharmaceutical Association council, were defeated. As a result, the pharmacy profession in Manitoba has not been able to move forward with progressive changes and practice which would allow Manitoba pharmacists to practise to the scope of their practice. Other provinces, for example, Alberta, have looked at Manitoba as a model to emulate based on the progressive content of the new pharmacy act of 2006. But now Alberta has implemented progressive regulations, and Manitoba is still in an impasse with these passage of these new regulations. The conflict between profession, self-interest, public

interest and patient safety are the major factors, I believe, in the defeat of the draft regulations.

I had high hopes on the health professions act to assist the pharmacy profession within Manitoba to overcome this impasse. I was, therefore, very surprised and disappointed to learn that the health professions act, sections 210, dealing with the pharmacy, was changed to allow pharmacists to continue to vote on their regulations, noting again that all other health professions in Manitoba do not have this privilege within the act.

The reasons for this exclusion have not been stated or brought forward clearly. This appears to allow the pharmacy profession to allow self-interest, business interests, et cetera, to play a major role in the governance of the pharmacy profession. I think we would all agree that since the publication of To Err Is Human report, the Canadian Adverse Events Study, and other patient safety research, that when we are making decisions regarding the health-care system today, patient safety is a major, if not the most important, consideration when making any decision regarding health-care services within Manitoba. Individuals usually feel they can balance self-interest with public interest and patient safety, but this is not always true. It's a juggling act. Self-interest always biases a decision, and true balance is difficult to achieve. One example of a confrontation of self- and public interest was apparent within the Manitoba pharmacy profession several years ago. Penny Murray already mentioned this where the MPhA council had developed a progressive pharmacists' learning portfolio to replace existing, outdate continuing education program. This would have put us–Manitoba–in more in line with most other provinces and states within the United States. This would ha–the pharmacist membership, as been told, voted this down. Whose interest was served with this vote and the results thereof? I am sure that the public would think that a reasonable, intensive, progressive continuing education program would be in the best interest of any individual obtaining medications from a pharmacy. Professional practice with respect to public safety is more important than self-interest or business interest and must remain separate.

The 2006 pharmacy act allows for a variety of progressive improvements with–within the profession of pharmacy, as number of people have mentioned. These are in jeopardy of not being instituted or significantly delayed due to the impasse in the regulation approval. Some of the improvements within the pharmacy profession include significant changes in the scopes of practice of pharmacists and technicians.

An expansion of the pharmacist's scope of practice would provide pharmacists the ability to practise to their full potential, contribute much more to improving the safety and the effectiveness of medication therapy. The 2006 pharmacy act provides pharmacists the opportunity to prescribe certain medications and to order certain diagnostic tests, to give an example. Pharmacists are currently recognized as medication experts whose role is to work in collaboration with patients, physicians and other health professionals to optimize medication management to produce posi–and produce positive health outcomes. Many research studies have demonstrated that pharmacists can have a positive impact on patient care in both the hospital and community pharmacy practice areas. The ability of pharmacists to prescribe medications in a collaborative relationship with physicians would enhance a pharmacist's ability to effectively and efficiently serve patients in Manitoba. This will become even more important as we reach the initial wave of the aging baby boomers and its impact on the health-care system within Manitoba. Unfortunately, other provinces, such as Alberta, and many states within the United States have already allowed pharmacists to prescribe medications and are way ahead of Manitoba.

The changes to the technician's scope of practice are an enabling and supportive component to allow pharmacists to spend more time providing direct patient care and impact on medication outcomes. This, again I must stress, is applicable to both the community and hospital pharmacy practice sectors. The 2006 pharmacy act would allow technicians to take on more technical activities within the drug distribution system and thereby providing more time for pharmacists to take on those clinical, direct patient-care activities, for example, more time spending educating patients regarding their medications–not that's being done now, just more time–more follow-up of medications regarding their compliance with their drug taking, monitoring the positive effects of medications and as well as their adverse effects–activities which, I must emphasize, have been shown to improve patient outcome. I need to stress again that this improved outcome has been shown in both community and hospital practice areas because there is no real boundaries where pharmacists can have their impact if they have the

time and the will to do so. And I must add that this probably–we've talked about differences between the hospital community and other sectors, but I think there's many similarities as well, I think. And I think we're all out for the public safety, with regards to medications.

In closing, the health professions act in Manitoba is overall a great piece of legislation which is long overdue. Exemption to allow pharmacists to continue to vote on the regulations not in keeping with the intent of the objectives of the health professions act can have a neg–negative impact on patients' and public safety. Passage of pharmacy regulation should be re–the responsibility of an elected regulatory body such as council with appropriate consultation with members and stakeholder organizations. This would be in keeping with the intent of the health professions act for all the other health professions. I urge you to please consider removing this particular exemption. Thank you.

Madam Chairperson: Thank you, Mr. Honcharik. We are at 11 o'clock, which we'd agreed to sit to. So I would ask if the committee has leave to entertain questions.

Some Honourable Members: Leave.

Madam Chairperson: Okay.

***** (11:00)

Ms. Oswald: Yes. Just more of a comment than a question. I, I want to thank you for staying this late, and, and providing this very well-documented and clear perspective. I appreciate also your acknowledgment of all of the other aspects of the legislation, you know, outside of the issues concerning pharmacy. I know that that's music to the legislative people's ears tonight because, of course, this does deal with, you know, many professions, and while we've been focussing for the most part on, on one issue concerning pharmacy, I, I do appreciate you saying that. And, again, I, I really thank you for being here and, and offering your counsel on this.

Madam Chairperson: Thank you. Thank you, Mr. Honcharik.

Just before I ask the committee what they want to do, I want to let those in attendance know that we will meet again tomorrow at 7 p.m. in this room.

The hour being 11 p.m., what is the will of the committee? What would you like to do?

An Honourable Member: Committee rise.

Madam Chairperson: Committee rise. Thank you very much.

COMMITTEE ROSE AT: *11:01 p.m.*

WRITTEN SUBMISSIONS PRESENTED BUT NOT READ

Re: Bill 18

Vision Council of Canada submission to the Standing Committee on Human Resources Bill 18, The Regulated Health Professions Act

June 2009

The Vision Council of Canada appreciates this opportunity to provide comments to the Standing Committee on Human Resources on Bill 18, The Regulated Health Professions Act. The VCC represents members of the retail optical industry and includes stores like the Bay Optical, LensCrafters, Real Canadian Superstores, Pearle Vision and Sears Optical.

The Vision Council supports the government's effort to update and modernize health profession legislation. Professional regulation should place the interests of patients and the public – not the professions – at the centre of the regulatory process. The Vision Council believes that Bill 18 by and large meets that principle.

There is, however, cause for concern. The first issue deals with what we believe may be the inadvertent capture of non-health profession corporations by the proposed definition of "health care", particularly as it relates to certain sections in Part 5, Practice in Association. The second issue is the potential to permit a health college to impose obligation on health professionals other than its members and on corporate entities.

The third issue is the Vision Council's belief that there is no legitimate public protection or potential for harm justification for the inclusion of "dispense" – as defined in the legislation – as a reserved act that may only be performed by a regulated health professional.

The Vision Council of Canada:

The VCC was established in 1989 with a mandate to ensure that the highest quality of eye care products and services are available to the public at a reasonable cost. Vision Council members operate in all Canadian provinces and U.S. States, and sell well

over 9 million pairs of eyeglasses per year across North America. They employ opticians and compete against optometrists (both are regulated health professions) for the sale of eye care products, relying for those sales on the prescriptions written by optometrists or physicians. In Manitoba, our members employ more than 200 people, including

The VCC has been an active participant in reviews and consultations concerning health professional regulation across Canada for twenty years, including those in British Columbia, Alberta and Ontario. Our focus is on how proposed legislation will affect eye care consumers and how it will impact our ability to deliver accessible and cost effective eye care products.

VCC Issue: Practice in Association:

In the definitions section, Section 1(1), "health care" is defined to include the sale of devices pursuant to a prescription. As such, corporate entities like the members of the Vision Council who sell prescription eyewear will be captured by this section and become providers of "health care".

Corporate members of the Vision Council do not perform the services of health professionals; as corporate entities they do not perform any reserved acts nor do they themselves carry out the scope of practice of a health profession. Our members employ and/or provide facilities and management services to health professionals who provide health care services.

The proposed definition, making them providers of "health care", would be a significant change from our current status and would require a major overhaul from the way they currently operate in Manitoba. Indeed, if this definition is allowed to proceed as is, Manitoba would be unique in Canada and the United States in capturing Vision Council corporate members in health profession legislation.

The Vision Council understands that the definition of "health care" is taken directly from Manitoba's Personal Health Information Act. While including the sale of a device may be appropriate in the context of the protection of health information, which may be shared with, or in part controlled by employing retailers, we do not believe that it is either necessary or appropriate in legislation designed to regulate health professionals. Sections (a), (b) and (c) appropriately define the essence of health care; the analysis and decision-making required of health professions are appropriately captured in these sections. But it is

The inclusion of the "sale" of an appliance e.g., eyeglasses, is particularly critical in relation to section 57 which deals with "practice in association".

Section 57(1) permits practice in association with regulated professionals who are members of the same or another profession, as well as "any other person providing health care".

Section 57(2) defines a "practice in association". The list includes many of the administrative and physical aspects of shared practice that VCC members currently provide for optometrists and opticians who work in collaboration and with non-health profession corporations. The precise services that can be shared vary across jurisdictions based on differing regulatory regimes.

The VCC believes that such sharing is in the public interest and promotes effective and efficient delivery of health care. However, the VCC is concerned that there will be unintended consequences from the way in which Bill 18 has been drafted.

We understand that it is not Manitoba Health's intention to capture corporate entities (other than pharmacies which are specifically addressed) in the Regulated Health Professions Act. We believe that position would be strengthened by the following amendment to the definition of "health care" shown in bold face:

"health care" means any care, service or procedure

(a) provided to diagnose, treat or maintain an individual's health;

(b) provided to prevent disease or injury or promote health; or

(c) that affects the structure or a function of the body;

and includes the sale or dispensing of a drug, vaccine, appliance, device, equipment or other item pursuant to a prescription, except that the sale or dispensing of an appliance or device by a corporation that is not a health professional corporation and that is done pursuant to the

A further concern about the possibility of unintended consequences occurs with section 57(3). This section imposes the ethical and confidential obligations of each associated member's profession on all other persons practicing in association. As drafted, this section will permit one regulatory College to impose

the ethical standards it develops for its members on members of another College with whom its members practice in association. Moreover, it has the potential to permit a College to impose these standards on unregulated persons or corporate entities that seek to work with health care professionals to provide services to the Manitoba public.

Ethical standards, which may be appropriate for one particular profession, may not be appropriate for, identical to, or consistent with the ethical standards imposed on other associated professions. Equally, the particulars may not be relevant to a non-health profession corporation, which has no voice in regulatory matters or decision-making by Colleges.

It is a fundamental principle of self-regulation that the individuals or entities regulated are limited to those who are members of the regulated profession in question.

In order to ensure the appropriate use of the authority granted to regulatory bodies by section 57(3), the Vision Council suggests the removal of section 57(3)(b).

VCC Issue: Reserved Acts:

As it relates to eye care, Bill 18 proposes the following reserved acts:

17. Prescribing, dispensing or verifying a vision appliance.

18. Fitting a contact lens.

In respect of a vision appliance, the legislation defines "dispense" as "to design, supply, prepare, adjust or verify it". (Section 3)

The Vision Council believes, however, that there is no legitimate public protection rationale or potential for harm that justifies the designation of "dispense," as defined, as a reserved act that may only be performed by regulated professionals.

In the course of twenty years of reviews and consultations in which the Vision Council has participated across Canada, no evidence or objective proof of harm in the dispensing of eyeglasses insofar as it relates to the design, preparation or adjustment of eyeglasses to adults has ever been shown. Indeed, there is limited evidence of any serious harm even relating to verification of the eyeglasses to the prescription.

Studies undertaken by the BC Health Professions Council, the Alberta Advisory Committee on Restricted Activities and the Ontario Health Professions Regulatory Advisory Council over the course of the past several years all found minimal if any risk of harm in dispensing. Indeed, the B.C. Health Professions Council was very clear in its findings: "The Council is not satisfied that there is a sufficient risk of harm in the dispensing of eyeglasses to justify including it on the list of reserved acts."

Moreover, our members' experience, literature searches and informal polls of opticianry regulatory bodies across North America have failed to identify specific findings of actual physical/medical harm.

Manitoba Health's Criteria for Regulation of a health profession supports our position that dispense as defined in Bill 18 should not be included as a reserved act. The criteria state, in part, that:

"A substantial risk of physical, emotional or mental harm to individual patients/clients arises in the practice of the profession, having regard to: (a) the services performed by practitioners of the health profession, (b) the technology, including instruments and materials, used by practitioners, (c) the invasiveness of the procedure or mode of treatment used by practitioners." Most importantly, the criteria state that "The harm must be recognizable and not remote or dependent on tenuous argument." (Our emphasis)

In eyeglass dispensing "design" can mean choosing frames, colours and coatings; most often this is reflective of the customer's personal tastes and budget. "Supply" refers to the actual sale or hand over of product for payment, a primarily retail function. "Prepare" suggests the making of the eyeglasses. The vast majority of eyeglasses sold to adults are prepared by taking a lens that already has the required prescription in it, inserting it into an automated machine which then grinds it to fit the frame. This is performed by lab technicians in labs, some of which are directly in stores and others that are off site. Nowhere in Canada is the making of eyeglasses regulated or required to be performed by regulated individuals or entities. "Adjust" means the bending of temples and/or tightening of screws in frames. Drug stores sell kits that include small screwdrivers used to tighten screws in eyeglass frames and bending temples is equally straightforward. None of these functions poses any risk of harm to the consumer that would justify the inclusion of "dispense" as a restricted activity.

Finally, the Vision Council believes that the inclusion of all aspects of dispensing as a reserved

act diminishes the government's effort to update and modernize its health professional legislation.

The Proposed Amendments: Practice in Association:

The Vision Council recommends the following amendment to the definition of "health care" shown in bold face:

"health care" means any care, service or procedure

(a) provided to diagnose, treat or maintain an individual's health;

(b) provided to prevent disease or injury or promote health; or

(c) that affects the structure or a function of the body;

and includes the sale or dispensing of a drug, vaccine, appliance, device, equipment or other item pursuant to a prescription, except that the sale or dispensing of an appliance or device by a corporation that is not a health professional corporation and that is done pursuant to the

The Vision Council further recommends the removal of (b) from section 57(3).

Reserved Acts:

The Vision Council urges the Committee to amend section 4.17. of the legislation to remove 'dispense' so that the section reads: "prescribing or verifying a vision appliance".

Andrea Belanger, Vision Council of Canada

* * *

Good evening, my name is Dr. Sandy Mutchmor and I am the current President of the Manitoba Dental Association. Thank you for the opportunity to appear before the Committee and comment on Bill 18, The Regulated Health Profession Act.

As the regulator for the dental and dental assisting professions, the Manitoba Dental Association (MDA) appreciates the recognition in the document of a regulator's role in improving access to care, continuing competence and access to justice. A regulatory body cannot be distinct from the significant responsibilities a society places on a profession, but must mirror those expectations in its function. The MDA Board's position is what serves the best interests of the public serves the best interest of our profession. It places significant resources and efforts in these areas now; statutory authority will further enhance our abilities to promote the public interest.

Our issues in Bill 18 requiring clarification relevant to dentistry and dental assisting, focus on six areas:

1. Designation of health profession–sc. 8(1)(b)(i) and ss.77, 78(1), 78(3);
2. Definition of dental appliance, dispense, prescribe and prescription–s. 3;
3. Reserved act for performing a procedure–s.4, act3;
4. Reserved act for a dental appliance–s. 4, act 19;
5. Provision of fee-guidelines–ss. 10(3);
6. Restricted use of "doctor"–ss. 78(1), 78(3)

Designation of Health Professions–sc. 8(1)(b)(i) and s.78(3)

From an outside perspective, the name of the regulatory body may seem to be a minor consequence. As President, I have concerns a drastic change may have a detrimental impact on continuity of regulatory functions; reputation; and relationships with the public and membership.

The Manitoba Dental Association has had statutory responsibility to regulate dentistry in the province for 125 years. Unlike many provinces, an organization advocating for the interests of dentists has never evolved in Manitoba. A small profession; limited volunteer base; high administrative costs and member disinterest in lobbying may be some of the reasons a professional interest association does not exist. Manitoba dentists generally view aggressive marketing and government lobbying as inappropriate for a profession.

The MDA does perform some services for dentists and dental assistants - representing Manitoba on national issues and committees related to dentistry and dental assisting; voluntary dispute mediation between dentists; providing continuing education opportunities in the province; access to counseling services for personal issues which may impact their functions as a professional - the primary role of the MDA has always been regulating dentistry and dental assisting in the public interest. The Board requires that any activities of the MDA cannot conflict with our statutory public interest duty.

The MDA does not advocate on behalf of individual members to either the government or other organizations. Any communications with the government or its departments is focused on public health issues including:

- institutional dental care for seniors;

- dental programmes administered by Employment and Income Assistance;
- improving recruitment and retention of dentists to rural and northern Manitoba with the Office of Rural and Northern Health;
- discussions with the University of Manitoba, Faculty of Dentistry on changes to admissions policies to improve access to care for underserved Manitobans.

Although a rose by any other name may smell as sweet, it would take a significant marketing campaign to make the public aware of the name change. Similarly, changing the name of a 125 year old regulatory body would require a considerable public awareness programme. The MDA has made a consistent effort to raise awareness and improve public knowledge of our organization; its regulatory functions; oral health information and the peer review processes. Those efforts will be lost if a significant name change occurs.

Any change will have considerable conversion costs associated with changing everything from the name on the door to accessing the website. All letterhead, binders and manuals will have to be redone.

The significant name change proposed will have far more significant costs and long term implications. The impact will be reduced awareness and access to the complaint process; reduced public awareness of roles and responsibilities of the newly named organization; dentist and dental assistant confusion or resistance about their statutory obligations to the newly named organization. 125 years of credibility and two decades of focused awareness and name recognition efforts will be lost.

The Board appreciates the benefit of uniformity in the designation of new regulatory organizations. If this was simply a new organization being authorized to perform the task of regulation, name would not be an issue. The challenge for dentistry and dental assisting is our regulatory tasks are ongoing. There are and will be complaints in the process of investigation and disciplinary hearings during this time of transition. The confusion and loss of credibility with the public and members is serious. Naming consistency must be balanced with the negative impacts the change would have on those ongoing functions and public confidence.

It is the Board's preference to minimize these problems for the organization and Manitobans. For continuity of regulatory functions; reduced public confusion; retention of well established relationships and trust; inclusion of all regulated members– dentists and dental assistants; and recognition of the important and ongoing contribution the MDA has made to regulation both in the province and nationally, please consider the continuation of the name Manitoba Dental Association. If this is not possible an alternate choice would be College of Dentists of Manitoba as the new designation for the regulatory body of dentists and dental assistants.

Definition of Dental Appliance – s.3

The broad definition of dental appliance in the document may present an issue for safe regulation. Currently, denturists are interpreting the current limited wording of their statutory authorized activities to allow for design, fabrication and fitting of any removable dental appliance including snoring/sleep apnea appliances, partial dentures with existing live teeth in the mouth and implant retained dentures. The vast majority of these tasks are performed without prescription as anticipated by The Denturists Act. Other jurisdictions recognize denturists performing these activities pose a risk to public safety. Private expressions of concern to their regulatory authority of their seemingly unilateral decision to expand a denturist scope of practice from dentures as described in The Denturists Act to dental appliances and examinations are politely disregarded. Denturists may be well aware of their Act's requirements for an oral health certificate or a prescription but many do not comply.

The MDA has to this point avoided publicly challenging the Denturist Association of Manitoba on this issue. Respect for their role as a regulator of a profession and our organization's reluctance to appear to be advocating a self interest or "turf protecting" underlies our hesitancy.

It is the MDA's hope the regulatory reform initiative by the Government will help clarify these issues by defining the roles and responsibilities through regulations of each health profession in an open and objective manner. The MDA concern remains public safety, and we anticipate this process will allow it to be the necessary focus of the review.

Definition of Dispense, Prescribe and Prescription–s.3

The three definitions in s. 3 have three interconnected issues. The definition of "prescribe" includes the authorization to dispense a dental appliance. The following definition of "prescription"

is limited to a drug. For consistency and clarity, the MDA would suggest including in the definition of "prescription":

"(a) in respect of a dental appliance a direction to dispense the appliance as designed in the directions for the person named in the directions;"

Organizations involved in the regulation of vision appliances and wearable hearing instruments may also consider this issue.

As design of a dental appliance is the most important factor in the appliance effectively performing the desired function, the MDA requests, for clarity, the definition of "prescribe" to expressly include the term.

A suggestion for drafting:

"(a) in respect of a dental appliance, ...to issue an authorization to dispense the appliance or instrument as designed for use by the named individual; and"

It may be necessary to have a separate clause for dental appliance as including design in the definition may alter the meaning for vision appliances and wearable hearing instruments. It may improve clarity to have separate clauses for the three activities in the definitions of "prescribe" and "prescription" similar to the definition for "dispense".

The definition of "dispensing" includes fabrication of a dental appliance. For my understanding when developing regulations, dental technicians normally perform the responsibilities of dental appliance fabrication for dental offices.

They are not a regulated occupation–would this task need to be delegated under clause 6(1)(c)?

Reserved act for performing a procedure–s.4, act3(a) and (d)

As scaling of teeth is specifically stated, does scaling of dental implants also need to be expressly identified as a reserved act?

Reserved Act for a Dental Appliance–s.4, act 19

The concerns are similar to those expressed with the definition of dental appliance. The broad nature of the definition will require careful application in the development of regulations of each profession to avoid unintentional consequences. The suggested change to the definition of "prescribing" would increase certainty.

Provision of Fee Guidelines–ss.10(3)

For the reasons previously described, the MDA is the only provincial dental organization. One of the tasks the MDA undertakes is to annually develop and release a fee guide. The fee guides are nonbinding and intended to provide information and descriptions to the public, dentists, third party payers and the government to aid the decision making process. The objective in developing the guide is the fees are fair and reasonable reflecting the time and intensity (degree of skill, risk, judgment, stress) of providing the services.

The MDA requests ss. 10(3) be modified to allow a dental regulatory body to continue to produce a voluntary non-binding fee list. The MDA position is based on the benefits the public receives from the production of a fee list. The public interest benefits are:

- Increased transparency;
- Complexity of factors necessary to consider in establishing a fee list;
- Public demand and expectation for the service;
- Improved patient access to information;
- Accountability to the public through Board approval process;
- . Ensures best practices in the development which has a pro-competitive effect;
- Improved productivity - by reducing individual practice and third party payer administrative burdens - can be passed onto patients.

Increased Transparency

A fee guide facilitates direct comparisons of prices by the public and government agencies not only between different dentists but also between general practitioners and specialists. These direct comparisons can occur between any region in a province and even inter-provincially (except Quebec). Without the fee guide, patients would need to place significant effort into understanding the services being offered; the coverage provided and the comparative value. Fee transparency would be dramatically reduced. The resultant inefficiency costs to insurers and dental offices would ultimately be passed to the patient.

Complexity of Factors

Every dental fee guide, including those produced by the MDA, contains a myriad of fees which are defined in technical terms to properly describe and differentiate complex services. The guide incorporate the common dental procedures from the Canadian Dental Association's Uniform System of Coding and List of Services (USC&LS) which is used by all third party payers for claims submission, processing and payment.

To help understand the quantity and complexity of dental services available, the current Manitoba fee guide for general practitioners contains 808 codes of the 2925 codes contained in the USC&LS and 612 fees. The services without fees are listed as independent consideration (I.C). To allow for easier price comparison, there is a preference to limit the number of I.C.'s and work in recent years to reduce their number in the guides.

In addition, the recommendations for the fee list are based on a detailed review of the province's economic conditions by an independent economic analyst. The factors include; the forecasted increases in employee wages of dental offices; other practice costs; inflation forecasts measured by the CPI; forecasts of base private sector wage and salary increases for Manitobans in the coming year; union settlements; and other economic conditions.

Within the fee guide, comparative value between individual dental services was originally established through comprehensive time/skill level studies analogous to those used for medical fees. Relativity assessment is reviewed as changes in technologies and practices occur. These complex reviews would be difficult for individual dental practices to perform.

Public Demand and Expectation for the Service/Improved Patient Access to Information

While appreciating the potential risks of a voluntary non-binding fee guide for a profession, when it comes to health care the public prefers and expects predictability and consistency in the costs of health care services. At the very least they need baseline information to assess the reasonableness of the service costs.

The MDA receives many complaints about dentists charging different fees from the fee guide. We have never received a complaint about dentists basing their services on the fee guide. Similarly, members of the public are usually surprised when they realize dentists have no obligation to follow the guide. These opinions are mirrored in news articles on the issue.

Asymmetric information and patient vulnerability require a high degree of trust between a doctor and patient. Once the necessary trust relationship is established, patients are very reluctant to change health care providers, seek second opinions or alternative fee quotes. Additionally, in dentistry the opportunity costs of acquiring alternative fee quotes usually outweigh any benefit which may be gained.

The benefit of having a responsible regulator produce a fee guide is it gives the public a cost free method of assessing the reasonableness of the costs quoted for their treatment. Moreover, it allows for increased predictability of coverage by their third party plan.

Accountability to the Public through Board Approval Process/Pro-competitive Best Practices

The system used to establish an MDA fee guide must comply with the Board's primary consideration of the public interest. To meet those expectations, the MDA relies on best practice criteria of the Competition Bureau of Canada and the United States Department of Justice Statement on Antitrust Enforcement in Health Care.

Briefly, the process consists of an independent economic analyst, contracted by the MDA, recommends the annual adjustments to each guide. An Economics Committee reviews these recommendations. The Board composed of members, dental assistant and public representatives appointed by the government receives and reviews the recommendations for acceptance, rejection or modification.

The inclusion of the independent economic analyst and public representation in the approval process ensures accountability in the process and reasonableness in the result. Manitobans pay some of the lowest costs for dental services in Canada because of the responsible, knowledge based approach of the MDA.

The Health Professions Regulatory Review Initiative is premised on finding a Manitoba way to avoid the challenges faced by the introduction of omnibus health professions legislation in other provinces. Manitobans benefit greatly from the MDA approach in publishing a voluntary non-binding fee guide. The advantages to the public interest of having a regulatory organization with public representation

willing to perform this task outweigh any theoretical disadvantages.

Improved Productivity by Reducing Dental Office and Third Party Payer Administrative Burdens

The MDA fee guide is accepted by all governmental and non-governmental third party payers in the province. A few vary the fees, but all rely on the relative valuation between the services. Without the fee guide, governmental and non-governmental third party payers would have to bear the cost of developing their own price list and negotiating pricing agreements on a dentist by dentist basis.

It would be financially and administratively costly for each of the over 400 dental offices in the province to produce a unique price list without an information base to rely. These costs would be passed on to the patients. The fee guide is voluntary and offices deviate from it based on their individual practice costs but usually retain the relative relationship between the services. In providing the public a relative scale of the costs and information, they may better judge the value of the services received from an individual dentist.

The fee guide and USC&LS benefit patients by facilitating the processing and payment of third party payer claims. By improving the administrative efficiency of dental offices and insurance companies, the time, inconvenience, uncertainty and expenses are reduced to the patient. The system creates predictability in processing which supports dentist acceptance of assignment for direct reimbursement from third party payers. The patient benefits further from reduced carrying and banking costs.

Restricted Use of Doctor–ss. 78(1), 78(3)

Clarification of the exception for academic or educational designation may be helpful. There have been occasions where we have, received information from the public about concerns they have with the care received from a "doctor". After further discussion with the complainant, the "doctor" is identified not to be a member of the MDA but usually a denturist. After clarification the individual is neither an MDA member nor a doctor, the complainant is referred to the appropriate regulatory body.

The concern is misrepresenting or misleading the public as to qualifications to perform reserved acts. Use of titles unconnected to the profession or business of individual; international degrees from unaccredited programmes and the increasing ease to forge false credentials can create confusion and distrust in the public. It makes professional regulation much more difficult and is a clear risk to public safety.

The concern is to ensure individuals will not use the academic or educational designations exception in ss. 78(3) to misrepresent their qualifications and mislead the public.

On behalf of the MDA, please consider these submissions in your review of the proposed legislation. Thank you for the opportunity to participate.

Dr. Sandy Mutchmor
Manitoba Dental Association

The Legislative Assembly of Manitoba Debates and Proceedings
are also available on the Internet at the following address:

http://www.gov.mb.ca/legislature/hansard/index.html