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Legislative Assembly of Manitoba

Standing Committee on Human Resources

Chairperson
Ms. Jennifer Howard
Constituency of Fort Rouge

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MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Ninth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON HUMAN RESOURCES

Tuesday, June 2, 2009

TIME – 7 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Ms. Jennifer Howard (Fort Rouge)

VICE-CHAIRPERSON – Ms. Bonnie Korzeniowski (St. James)

ATTENDANCE – 11 QUORUM – 6

Members of the Committee present:

Hon Mr. Chomiak, Hon. Ms. Oswald

Hon. Mr. Blaikie, Messrs. Briese, Cullen, Derkach, Mrs. Driedger, Ms. Howard, Mr. Jennissen, Ms. Korzeniowski, Mr. Whitehead

APPEARING:

Hon. Jon Gerrard, MLA for River Heights

WITNESSES:

Bill 18–The Regulated Health Professions Act

Mr. Scott McFeetors, Private Citizen
Mr. Greg Harochaw, Private Citizen
Mr. Gerald Clement, Manitoba Chiropractors' Association
Mr. Greg Stewart, Private Citizen
Mr. Bill Eamer, Private Citizen
Mr. Brian Head, Private Citizen
Mr. Don Nazeravich, Private Citizen
Ms. Colette Raymond, Private Citizen
Ms. Danica Lister, Private Citizen
Ms. Verna Holgate, College of Licensed Practical Nurses of Manitoba
Mr. Wayne Rivers, Procurity Inc.
Mr. Doug Penner, Private Citizen
Mr. Elmer Kuber, Private Citizen
Mr. Mark Scott, Private Citizen
Mr. Brent Penner, Private Citizen
Mr. Curtis Unfried, Manitoba International Pharmacists Association
Mr. Mel Baxter, Private Citizen
Ms. Barbara Sproll, Private Citizen
Mr. Pat Trozzo, Private Citizen
Mr. Jeff Uhl, Private Citizen
Mr. Blake Taylor, Private Citizen

WRITTEN SUBMISSIONS:

Bill 18–The Regulated Health Professions Act

Sandy Mutchmor, Manitoba Dental Association
John E. Gray, Canadian Medical Protective Association
Andrea Belanger, Vision Council of Canada

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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Madam Chairperson: Good evening. Will the Standing Committee on Human Resources please come to order.

Our first item of business is the election of a Vice-Chairperson. Are there any nominations for this position?

Mr. Gerard Jennissen (Flin Flon): I nominate Ms. Bonnie Korzeniowski.

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

No other nominations? Hearing no other nominations, Ms. Korzeniowski is elected Vice-Chairperson.

This 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 lists before you, and there are a couple changes–a few changes to those lists that I'll just read for you. Presenter No. 12, John Myers, is not appearing this evening. You will–

he has decided not to present. And then we have four additions: No. 18, David Wayne Rivers from Procurity Inc.; No. 19, Mark Scott, private citizen; No. 20, Doug Penner, private citizen; and No. 21, Brent Penner, private citizen.

Before we proceed with presentations, we have a number of other items and points of information. I'll ask in advance for your patience as I read through these.

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 are 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 at the back of the room. As–or at the front of the room, I–it depends where you're sitting; to me, it's at the back of the room. If you need help with photoco–yes, 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 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.

I will note that last night we agreed to hear out-of-town presenters first. We did call those names and then proceeded to hear Winnipeg presenters. We also called a few people who were not in attendance and who were therefore dropped to the bottom of the list. Tonight, we'll pick up where we left off, hearing the remaining Winnipeg presenters before doing a second call on the other presenters.

A written submission on Bill 18 from John E. Gray, CEO of the Canadian Medical Protective Association, has been received and distributed to committee members; you'll find that at your seats. Does the committee agree to have this document appear in the *Hansard* transcript of this meeting?

An Honourable Member: Agreed.

Madam Chairperson: That is agreed.

How long does the committee wish to sit this evening?

Hon. Dave Chomiak (Minister of Justice and Attorney General): Till we hear all the presenters.

Madam Chairperson: It's suggested that we sit until we complete the presenters. Is that agreed?

Some Honourable Members: Agreed.

Madam Chairperson: Agreed.

Prior to proceeding with public presentations, I would like to advise members of the public regarding 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 person's name. This is the signal for the *Hansard* recorder to turn the mikes on and off.

Thank you for your patience. We will now begin with our presentations.

Bill 18–The Regulated Health Professions Act

Madam Chairperson: I would like to call Scott McFeetors.

Welcome, Mr. McFeetors. You can start whenever you're ready.

Mr. Scott McFeetors (Private Citizen): A little bit nervous.

Good evening, Madam Chair, honourable minister, honourable committee members, ladies and gentlemen, colleagues, partners, and partners in the pursuit of optimal health outcomes for Manitobans.

My name is Scott McFeetors. I've been a licensed pharmacist in Manitoba for a total of 19 years. I've also been licensed in Ontario for the past 10 years. I've been a community pharmacist in Manitoba for Loblaw companies for the past 10 years, and prior to that I worked as a pharmacist at the Health Sciences Centre here in Winnipeg both in sterile products/oncology and in the pediatric intensive care unit. My current role is as a director of pharmacy operations for Manitoba and northwestern Ontario, supervising 23 pharmacies.

Firstly, I would like to state that I am a strong proponent of Bill 18 and I would li–like to sincerely thank all of the people who were involved in its development, consultation and drafting. It was

obviously a daunting task, but it is a great piece of legislation that serves to put the health professions of Manitoba at the forefront of health care in Canada.

I like the bill so much that I don't want to change anything about it. This would include, of course, the retention of the voting rights of the membership of the college of pharmacy as defined in sections 210 and 211.

As a mana–member of the Manitoba Pharmaceutical Association, a pharmacist, and as a member of the public at large, I believe it is my duty to actively participate in the activities and meetings of the association and to have a clear understanding of the direction in which the profession of pharmacy is taking. I have been a member of the MPhA discipline committee for five years. I've taken part in subcommittees and ad hoc committees of the association, and I make it a priority to be both present at and to have my vos–voice heard at all meetings of the membership.

Having said all that, the first thought that comes to my mind is, when did business become an ugly word? The honourable committee members have heard from numerous speakers from the MPhA and hospital practice that business does not have a place in the regulation of the practice of pharmacy. Canada is based on a free enterprise system that encourages and protects the rights of businesses large and small. To say that the business component of pharmacy does not have a place in the regulation of pra–regulation of practice of pharmacy is ludicrous, in my opinion.

The profession of pharmacy has developed from simple roots, first and foremost, being the independent pharmacy. I certainly have not heard members from hospital practice complaining about their level of remuneration, which has escalated as a direct result of competition in the business sector. As a community pharmacist, I'm a strong proponent of the great majority of proposed regulations that were put forward to the membership vote in March of 2007. And to clarify, there has only ever been one vote on those proposed regulations, not many like other speakers have alluded to. I voted against the proposed regulations because of only a few regulation proposals that I could not endorse. I believe that most community pharmacists, who make up 73 percent of MPhA's membership, feel the same way I do. I am 100 percent in favour of prescribing privileges, extended practice pharmacists, expanded roles for pharmacy technicians, including tech-check-tech provisions, the ability to order and interpret lab tests, telepharmacy, centra fill–central fill and automation, to name a few of the innov–innovative regulations put forward.

Why does the hospital sector feel that their community counterparts are, as a whole, against everything that has been proposed? Many community pharmacies are at the forefront in innovation: outpatient IV programs, methadone programs, specialty compounding, patient health clinics, colleague education programs, home visits, public speaking and medication reviews are but a few of the innovative programs out in the community realm.

In my own experience, I have been intimately involved in the development of an extensive technician training program, a standardized workflow initiative that is intended to utilize the expanded role of the technician and free up pharmacists for greater pharmaceutical care, and others. I promote and strive for excellence.

So why is pharmacy unique and why does it deserve to be treated differently than other colleges under Bill 18, specifically with regards to voting rights? The role of the Manitoba Pharmaceutical Association had to be defined in the Act itself because its scope extends beyond that of all other colleges. The role of MPhA encompa–encompasses regulation of the profession as well as regulation of the business of pharmacy. The large majority of community pharmacists prac–practise in an overtly commercial environment. This, by itself, makes pharmacy unique from other professions.

***** (19:10)

I'm sorry to say that the infighting and polarization that has resulted from the council's inability to accept the recommendations of the membership is also something that sets us apart from the other colleges and makes us unique.

Having worked as a hospital pharmacist for a number of years, I can appreciate the differences between the two work environments. These differences, in my opinion, serve as proof of the uniqueness of the pharmacy profession, as hospital practice is granted distinction under several pieces of legislation and professional documents.

Hospital pharmacies have their own standards of practice and guidelines on practice in hospital pharmacy that is different and distinct from that of

community pharmacy and long-term care facilities. In fact, the guidelines on hospital practice in hospital pharma–guidelines on practice in hospital pharmacy are a document that appears to be a complete set of regula–set of regulations for hospital practice. They have different requirements for patient medication profiles, labelling, patient counselling, drug information service provision. Each hospital develops its own formulary, which is completely li–unlike the requirement for community pharmacies.

Community pharmacists, on the other hand, are the face of the profession that the public sees the majority of the time and are the primary source of information and consultation on prescription medications and over-the-counter products. In fact, many people are unable to see a physician for minor ailments and attend community pharmacies for advice and treatment. Community pharmacies–or pharmacists are vigilant to drug interactions, side effects of medication, allergies, contraindidicaca–excuse me–contraindications and potential cases of abuse.

In pointing out some of these differences from community practice–from community pharmacy practice, my point is that hospital pharmacy practice has been accorded the distinctions that it has required, and this has been accomplished with the membership's right to vote in place. Taking into account that 73 percent of Manitoba's pharmacists are community pharmacists, I can't see why pharmacists would support a measure to take away their voting privileges.

Some of the arguments we heard yesterday. One, that by maintaining the right to vote, pharmacists will be stuck in the dark ages of lick, stick and pour, in purely a dispensing role. The greatest majority of community pharmacists have embraced pharmaceutical care and the Blueprint for Pharmacy that has been alluded to last night, which has been endorsed by, among others, 19 of the largest retail pharmacy change in–chains in Canada. This alone demonstrates that community pharmacy is fully behind these initiatives.

Number 2 argument is the membership voted only with self-interest in mind. Now, self-provision–self-preservation may be a better argument, but acting in self-interest may be more applicable to a council who chose not to consult or act upon recommenda–recommendations made by the membership.

Number 3. Inconsistency and lack of harmonization with other colleges will lead to public harm. The fact that, aside from the situation at hand, there has been no real issue with voting rights inhibiting MPhA's advancement of regulations or by-laws or code of ethics, there no–there's no reason to think that the current system cannot work. The regulations are the meat and potatoes of the profession. It warrants getting it right the first time.

Another argument was, they have the right to vote, but not many do. Well, that's very interesting because approximately 40 percent of the membership voted on the regulations document. If this is insufficient to retain voting privileges, then I assume the same argument should be used for voting in provincial and municipal elections, which had 48 and 38 percent voter turnout respectively in the last elections. Should we take away the public's right to vote?

Older pharmacists are afraid of change. Now, new graduates in our profession have the knowledge and exuberance for change, but some of us older pharmacists–and I include myself in that group–have, have experience and are equally open to the advancement of the profession.

Another argument was that members don't–didn't understand what they were voting for. I think the Manitoba Society of Pharmacists did an excellent job of providing the tools that the members needed to make an informed decision, and MPhA as well should be commended for their efforts during the summer of 2007 and all the information sessions that were held.

Number 7. Companies forced people to vote in a certain way. Are pharmacists children? Did the WRHA instruct their employees on how to vote? Because there certainly seems to be a large proportion of their management present at these hearings.

The membership and its professional ag–advocacy group can lobby, but the MPhA council can't. By the statements made by leaders of other colleges, as well as the unified stance of the hospital pharmacists present, it's obvious to me that lobbying by MPhA has taken place.

The Canadian Pharmaceutical Journal–and I gave a copy for everyone there–in its March/April 2009 issue published an article entitled, "A qualitative inquiry into the practice experiences of

community pharmacy managers" that concludes that, and I quote: "Community pharmacy managers are the link between pharmacy organizations and the employees, including staff pharmacists and others. The dynamic perspective shared by each of these unique professionals highlights the fact that many models and cultures exist in practice today. However, a common vision of putting patients first–"

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

Mr. McFeetors: "united all interviewees, a vision that must be relayed to all stakeholders. . ."

Since Bill 41 was introduced in 2006, the council of MPhA, in my opinion, has done everything that they could possibly do to further a mandate that was not entirely supported by the membership. They have not been amenable to suggestions or compromise and conveniently blame their membership and not their own unreasonableness for the inability to get a set of regulations passed. The fact that 66 percent of the membership voted against the regulations should be a wake-up call for everyone.

What possible solutions are out there: No. 1, we could add a clause to Bill 18 to revisit voting rights; No. 2, we could remove the most contentious regulations; No. 3, we could create separate regulations for hospital pharmacy and remove their right to vote; or 4, and this is the least appetizing one, we could remove licensing authority and commercial regulation authority from MPhA.

Madam Chairperson: Thank you. Your time is expired. Thank you.

Questions?

Hon. Theresa Oswald (Minister of Health): Not a question, just a comment. I think you were one of the stalwarts that were here until late last evening, and when you were the next one on the list–how disappointing is that? So thank you for coming back and thank you for a well-crafted argument.

Hon. Jon Gerrard (River Heights): Thank you. You've very carefully *[inaudible]* negative vote on the regulations. Now I understand that there's actually very little difference right now in terms of the regulations. Can you help us understand what the problem is in terms of, or the difference is outstanding in terms of the regulations being proposed and what would be acceptable?

Mr. McFeetors: For me personally, and others may have a different view, some of the things that I had an issue with was the issue of a ban on inducements for pharmacies, the ability to compete that was outlined under this, something considered under the Sheridan Scott report. Again, pharmacy manager qualifications, putting in an arbitrary number of minimum hours that a pharmacist would have to work before they could be considered a pharmacy manager, when as far I'm aware, all other health professions, as soon as you graduate, you're eligible to open up your own business should you so desire and, as an earlier speaker had alluded to, many rural pharmacies, it is, in fact, a new graduate who goes, goes to a smaller community and becomes the pharmacy manager and sole pharmacist in that location.

So those are two of the issues that I had, are probably the ones that I had the, the biggest contention with. Some of the other ones, just minor things, but were those addressed, I mean, I would probably have voted in favour of, of the proposed regulation package. And as I said before, I mean, 90 percent of it I was in agree–total agreement.

Madam Chairperson: Thank you, Mr. McFeetors.

Next I'll call Michelle Glass. Is Michelle Glass present? Michelle Glass. Her name will drop to the bottom of the list.

Next on my list I have Greg Harochaw. You can begin whenever you are ready, sir.

Mr. Greg Harochaw (Private Citizen): Okay, Madam Chair, members of the committee. My name is Greg Harochaw, and I wish to make a presentation as a private citizen in support of Bill 18, as currently written.

I'm a clinical retail pharmacist and I specialize in palliative care, pain management, erectile dysfunction. I have worked retail for 27 years in Manitoba and I believe I represent both hospital and retail pharmacy, although I am not a hospital pharmacist. I feel that because of my clinical expertise. Clinical pharmacists, at one time, were only present in hospitals and not in retail pharmacies. I'm sought out for my advice from physicians, nurse practitioners, nurses and home care workers, both in the community and hospitals, as well as the public.

I have been a guest speaker at the St. Boniface Hospital Palliative Care, WRHA Palliative Care, Health Sciences Centre Pain Clinic, Health Sciences Centre Radiation Oncology, North American

National Pain Conference, regional palliative care conferences, St. Boniface Family Physician Rounds, Manitoba Physicians Annual Conferences, Manitoba Schizophrenia Society, village clinic, Workers Compensation Board, Manitoba Mental Health, Victoria Hospital, Concordia Hospital, Steinbach Hospital, Deer Lodge Centre. I have provided educational seminars for physicians, nurse practitioners, nurses, pharmacists and the public in Winnipeg, Brandon, Portage la Prairie, Thunder Bay and Calgary.

***** (19:20)

I'm a retail pharmacist, and I represent 75 percent of the pharmacist work force. You're going to hear mostly from hospital, retail, our associations and respective councils, and it saddens me when I already know ahead of time who's going to support the voting rights of pharmacists and who wants to remove that.

Our MPhA register, assistant registers and council, I believe, try to make the best decisions for my profession, but I believe they don't always make the best decisions. Look at Internet pharmacy. Every year when I renew my licence, it seems like every year there seems to be some way of trying to stop that from going through for my profession. Why? It has cost hundreds of thousand dollars in legal fees. Our reigning government supports Internet pharmacy. Why can't they just drop it and move on from there? And I really believe as long as MPhA has ability to license your pharmacy operations, we should have a right to vote; otherwise, Internet pharmacy, as an example, may not be around tomorrow.

I'm very passionate about my profession, and I decided to be involved directly in development of my profession in various roles. I ran for council for MPhA in 2003 as I felt that retail pharmacy was not best represented by our council at the time, and I was hoping to try and make changes for my profession. When I wasn't elected, I served on numerous committees, including WRHA palliative care subcommittee, where I worked to develop home emergency kits that are currently used for people choosing to die at home. I am a member of the Manitoba Hospice and Palliative Care Annual Conference Planning Committee, the MPhA Standards of Practice and Methadone Subcommittee, the MPhA Residential Care Committee and the MSP Personal Care Home Negotiating Committee.

As a retail pharmacist, I am not opposed to most of the issues of Bill 41. As I mentioned, I sat on the MPhA Standards of Practice and went over Bill 41 proposed changes to pharmacy. At times it was frustrating because, when a question sometimes was asked what a particular statement meant, it wasn't common to hear, I'll have to ask the lawyers to get back to you. And so this is happening at our–at the council level that's going through this at standards committee. So why is it uncommon our members need better clarification of an act that will change the face of pharmacy in Manitoba?

I was also involved in a subcommittee involved in trying to resolve one of the contentious issues. An issue that I sat on was passing the regulations and how they should perhaps be done. We were mandated to find a solution before September 2008. I felt really good with we had found a solution. However, that was turned down by MPhA council April 17, 2009. It seemed like the only issue the council was concerned with was the right to vote to be taken away.

For a long time, hospital pharmacists were the only ones who could compound non-commercial products. I work at Tache Pharmacy; some areas of compounding we surpass what hospital pharmacists can do. I don't say this to demean my fellow workers. I think it's great to take what they have started and bring this to the retail level.

With this said, when I asked my association if I could use the tech-check-tech program system adopted at hospitals, until yesterday I was denied. Why am I not allowed the same rules hospitals are allowed to use for using technicians? I truly feel that a use of pharmacists' time is not in the preparation of product, but information we hold to be disseminated to our client. I've heard people say that retail pharmacists don't want this expanded role for technicians. I argue that point. With our profit margin shrinking, we need to be as viable as possible. With increasing technician use, this definitely will help.

I really feel, for what a pharmacist has to offer the public with his or her knowledge base, we are totally underutilized. The ability to prescribe, for instance. We are diagnosticians, albeit not near the extent of physicians, and we should be able to have limited formulary prescribing rights to help out with our health-care system. As the role of clinical pharmacists continues to expand into the retail work

force, this further speaks to prescribing rights. Once something has been diagnosed, we are experts on what medication should be given.

We need to use our technicians in expanded roles of filling our medications to free up our pharmacists. We need to develop safeguards which allow them to do this part of the job safely. We need to change the traditional roles of pharmacists and bring them into roles of information givers and prescribers.

People talk about how retail pharmacy is only interested in profit, and that offends me. For people don't like talking about viability. In hospitals and the WRHA, people work from a budget. In retail, as I mentioned earlier, we need to be viable or we don't exist. Changing how pharmacists are able to collect income and better use of our technicians is critical.

Automation is another role not only used by hospitals, but also retail pharmacy. At Tache Pharmacy, our work, we have a sterile hood, we make sterile products used in retail that otherwise may not be available to the public. This is made by my technicians. We have a pill packaging system called PACMEDS which is used in personal care homes, and we offer this to the community base to be used. My technicians operate this. I have specialty software and equipment that allows me to make products most hospitals, hospital and retail, cannot make–or most pharmacists, hospital and retail, cannot make. And it's made by my technicians.

I've heard arguments about–of how allowing pharmacists voting rights on our regulations do not protect the public. I know of no pharmacist who wants to use their malpractice insurance. Everyone I know who makes an error feels bad about it for weeks. Because our council may not fully have the best ideas, they may try and pass a regulation that will protect the public, but it may actually hinder retail pharmacy when it comes down to administering that new rule.

When I worked at Canada Safeway, every now and then the hierarchy would decide we should do something different. Most of the time the ideas were great, but sometimes they were difficult to implement. Allowing us to have the right to vote will maintain patient safety as we are front-line workers in the area, not the people who work the hospitals, WRHA or our association, but retail pharmacists who represent 75 percent of the pharmacist work force.

People are going to–to present about why should pharmacy be allowed to vote on its regulations whether–when either group in Manitoba do not have this or other provinces that regulate pharmacy also do not have this. Does that make it wrong what we do? Is it a safeguard in our profession that perhaps other bodies should have?

In closing, I do not support amendments which remove the pharmacist's right to vote directly on regulations to the changes that govern my profession and the code of ethics. I support Bill 18 in its current version and would support amendments which would–and would not support amendments to remove the pharmacist's long-standing legal right.

Madam Chairperson: Thank you.

Ms. Oswald: Yes, thank you, Mr. Harochaw, for being here this evening and for crafting a fine argument to present to our debate tonight. Thanks again.

Madam Chairperson: Thank you very much for your presentation.

Next on my list, I have Gerald Clement from the Manitoba Chiropractors' Association. You can begin whenever you're ready, sir.

Mr. Gerald Clement (Manitoba Chiropractors' Association): Thank you, Madam Chairperson, honourable Minister of Health, other honourable ministers, members of the committee.

I'm honoured this evening to make the following presentation on behalf of the board and members of the Manitoba Chiropractors' Association regarding Bill 18, The Regulated Health Professions Act.

While I'm not a chiropractic practitioner, I believe that my personal background and involvement in the chiropractic profession, as well as my professional tenure in the public service of Manitoba, have given me a special perspective on the matter before the committee this evening.

As mentioned, my name is Gerry Clement and my involvement in chiropractic began well over 40 years ago. One of my closest and lifelong friends chose chiropractic as a profession, and because of our relationship I was able to appreciate this profession through the eyes of a student, a new doctor of chiropractic, a conscientious and tireless practitioner, an inspirational leader for his profession, and a devoted member of his association. My friend, the late Dr. Gilbert Bohemier, was

passionate about his profession and, more importantly, about the welfare of his patients.

While I was a patient of Dr. Gil's, our friendship and interest in each other's profession allowed us to share our ambitions and insights into what we wanted to contribute and possibly leave as a legacy to the generations that follow. Yes, we were dreamers. We set our targets high, but our lofty goals were always underscored by a genuine interest in helping others and making our province the best place to live, work and raise our families.

In 1990, Dr. Bohemier became the president of the MCA. That year he invited me to serve as a public member on the board of governors. Over a period of two years, I attended monthly meetings and witnessed first-hand the role and function of a regulated profession to ensure the highest standards of care for all chiropractic patients while serving their members in all of the various activities outlined in section 10(2) under Mandate of college in the current draft of the regulated health profession legislation.

During my tenure as a board member, I also witnessed the ever-demanding task of serving one's membership, ensuring standards of practice, meeting expectations of various committees, providing appropriate guidance and response to mandated agencies, all the while being an active practitioner. In 1992, I conducted a feasibility study on the benefits of establishing a permanent and formal office for the MCA. My report was overwhelmingly supported by the membership, and during the set-up phase, I made a critical decision to request a leave of absence from the civil service to serve as the MCA's first executive director starting in February 1993. I held this position for four years, and looking back, it is a cherished and valued period of my professional life. Under the guidance of successive boards, especially their presidents, we made significant advances for patient care and membership services alike, making Manitoba one of the most innovative leaders in chiropractic care across Canada. I am honoured to be a part of that history.

***** (19:30)

Through this experience and with a clear understanding of the purpose of The Regulated Health Professions Act, I can understand why the association has been fully supportive of the overall provisions of the proposed legislation. The act will strengthen and modernize the governance, the accountability and transparency of all health professionals and will enhance patient safety and consumer protection.

I also understand through Dr. Dan Wilson, the chair of the MCA's legislative review committee and Dr. Greds–Greg Stewart, the executive member of the world chiropractic–World Federation of Chiropractic and a past president of both the Canadian Chiropractic Association and the MCA, both with me this evening, that the association has been actively involved in the consultative process established by the Department of Health for this purpose. The department has had a daunting task to develop this comprehensive legislation, understanding its potential effects on all affected professions, both current and future.

Manitoba is the fifth provincial government to introduce legislation to regulate health professions. The other jurisdictions, of course, were Québec, Ontario, British Columbia and Alberta, provinces with significant numbers of practitioners in all disciplines.

The approach taken here in Manitoba should take into account the impact of some of the provisions on associations with a limited membership. It may be difficult to assess the impact when the act is implemented, so it is important to include flexibility; to mitigate unforeseen circumstances.

As mentioned previously, the MCA supports the purpose and intent of the overall legislation. But one suggestion that we offer to the committee this evening is not specifically for the chiropractic profession, but for all professions involved. We suggest provisions that provide greater latitude to the minister responsible for the administration of the act well into the future.

Under the heading, College, section 9 through 11, this defines the powers, duties, mandate to membership of the colleges, which we assume each individual profission–profession will be required to establish following the passage of this act. Section 10(3) states the college may not set fees, provide guidelines for professional fees or negotiate professional fees on behalf of any or all of its members. In assessing this particular provision, each profession will have to consider the implications of having their college mandated under this act but, at the same time, having to be represented by another

form of association for the purposes outlined in section 10(3).

In those provinces where the membership levels are significant, the latter point may be mute. But as jurisdictions with a smaller population membership base, such as Manitoba, introduce similar legislation, it is apparent that imposing this separation may have a significant impact.

It is interesting, however, in looking at existing statutes in those provinces where similar legislation is in place, not one of those jurisdictions chose to include provisions for ministerial consideration to grant a college the authority to set professional fees, and to negotiate fees on behalf of some or all of their regulated members. Naturally, the college must meet conditions imposed by the minister for that approval. We also understand that this concern is shared by other health-care professions and we trust that they will also make their concerns known in this regard.

On March 16, 2009, Dr. Wilson wrote to departmental staff outlining the MCA's rationale for recommending similar wording in Bill 18, and we sincerely hope that the minister and her colleagues will give this suggestion appropriate consideration.

In conclusion and with the committee's indulgence, I'd like to add a few more personal anecdotes which I believe relevance to this presentation. When I returned to government in 1997, I was very fortunate to begin the most exciting and rewarding segment of my career, that of assistant deputy minister responsible for immigration, settlement and multiculturalism. At that time, Manitoba was a passive participant in a shared federal-provincial jurisdiction. All that changed in the following decade. Manitoba developed an innovative and proactive strategy which looked at our needs, at our opportunities, and developed a variety of flexible programs which pushed us ahead of all other provinces. As one of my all-time favourite ministers, the honourable Nancy Allan, repeated time and time again, in all kind of fora, we simply don't take a cookie-cutter approach in Manitoba. And this policy and direction continues to this day.

In closing, the members of the MCA welcome Bill 18 and trust that the Manitoba regulatory health professions act will include special prevention–provisions and flexible approaches that are essential to best serve all Manitobans today and for years to come. Thank you.

Madam Chair, I'd also request leave to invite Drs. Wilson and Stewart to join me for any of the questions that may be more of a technical nature.

Madam Chairperson: Is there leave of the committee to do that?

Some Honourable Members: Leave.

Madam Chairperson: Agreed.

Mr. Clement: Thank you.

Madam Chairperson: Questions, I have.

Ms. Oswald: Yes, just a comment. Let the records show she's one of my favourite ministers too.

And I–certainly, the issue of splitting the advocacy role and the role of the college proper has been a subject of much debate, and I appreciate your suggestion and point of view on this issue, and I'm sure that we're going to be able to find a way going forward to, to make this work as best as possible for all professions. We want this to be about making better, not making more complicated.

So I thank you for being here tonight.

Mr. Gerrard: Thank you for the presentation, and, just two points: one, just for clarity, are you suggesting that there be an amendment to the act so that professions with, you know, I think it's smaller numbers of people would be able to set fees and so on; and, the second point, yesterday we had a presenter who raised concerns about–I think it was high neck manipulation and the association with stroke, and I wanted to give you an opportunity to, you know, provide a point of view on that.

Madam Chairperson: I'm just going to have to ask you to introduce yourself before you speak.

Mr. Greg Stewart (Private Citizen): Yes, my name is Greg Stewart. I'm a chiropractor in St., St. Vital for 23 years and I'm a past president of the Manitoba Canadian associations and I'm on the executive of the World Federation of Chiropractic.

This is a topic that, that we've taken very seriously, and we've done extensive research because there has been an association between vertebral artery stroke and chiropractic manipulation, and this was taken–and this goes beyond these borders, for certain, and this has been addressed from everywhere from the World Health Organization. And I brought

two documents that have been published last year, one in French, one in English, from the WHO regarding the WHO guidelines on basic training and safety in chiropractic in which those questions are addressed.

Quite succinctly, however, they're–they also started at–or in the middle of what's called the bone and joint decade established by the WHO, and in there they establish a neck pain task force which involved 14 professions, nine countries and a very extensive 7-year, $5-million review of the literature, 23,000 medical citations, a thousand critical reviews of research, and they published in *The Spine Journal*, the worldwide–both North American and worldwide versions–addressing this issue. And to hope this doesn't get too long and tedious, but the study was–is a Canadian study and it was done in Ontario when they did a tracking study of looking at the association between manipulation and stroke. So they evaluated 55-million life years of data, and it's hard to do a study larger than this. They did an Ontario population, 11 million people over a five-year period, and they looked at this very rare type of stroke. It's hard to study something that's this rare. You can't do a prospective study. You have to use a retrospective study because the–you have to have a huge inclusion of population to have–make any conclusions regarding association.

When they analyze the data on the small numbers and they broke them out into this population that has this rare type of stroke, when they analyzed the Ontario health data, they found that these people who suffered this type of stroke were just as likely to have just visited a medical doctor, actually, even slightly more so than a chiropractor.

So this shed some new light on the topic, because this originally was correlated to a procedure, but what we've really found now is that these people have what are called strokes in evolution, and so the presenting symptom tends to be neck pain and intense headache, and so people tended to go to the profession of their choice to address such an issue. So some went to an MD, some went to a chiropractor.

So when they analyzed the visits of practitioners and looked at the ICD9 codes of the previous month, they found that there was exact same–pretty much exact same correlation where they went to see an MD or a chiropractor. And, obviously, the medical doctor isn't manipulating them, but just that these strokes, once they start you just are–have to–you just hope you're not the unfortunate one to have seen them later–seen the last one to see them.

So what we've started–a program of identifying them when they walk in your office so that you can channel them as fast as possible. In other words, when someone comes into a, an intense, severe headache or neck pain like they have never experienced before and there's no associated trauma, that they get sent off to a referral as fast as possible, and so we can identify these strokes in evolution so they can be appropriately managed. In other words, they're not going to be amenable to any treatment, either a pra–a general practitioner or a chiropractor can provide in his office.

***** (19:40)

The Canadian Chiropractic Association has also developed extensive clinical practice guidelines for the membership regarding the treatment of neck pain. We'll be utilizing–we'll be updating with the information developed by the Neck Pain Task Force at WHO as well as disseminated internationally through the WHO guidelines on basic training and safety in chiropractic. We are doing–

Madam Chairperson: Thank you, Mr. Stewart. The time for questions has expired. Thank you very much.

Mr. Stewart: You're welcome.

Madam Chairperson: Thank you.

Our next presenter is Bill Eamer. I should also just take the opportunity to let the committee know that we've had an addition to the list: No. 22, Curtis Unfried of the Manitoba International Pharmacists Association.

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

Mr. Bill Eamer (Private Citizen): Thank you, Madam Chair, Minister Oswald, committee members. Thank you for your attention. By way of introduction and background, I am a chartered accountant by profession, a retired employee of pharmacy and, proud to say, an honorary member of the Manitoba Pharmaceutical Association.

My objective this evening is to address the manner by which professional regulations are to be implemented under Bill 18. You, you heard last night the first of several presentations: Mr. Stephanchew,

the president of MPhA; Professor Colleen Metge, a professor of pharmacy at University of Manitoba; a number of others, including representatives of the College of Physicians and Surgeons and the College of Registered Nurses of Manitoba, whose stated position–their recommendation was in favour of standardization across Manitoba's health-care professions.

My particular mandate this evening is to present a submission that was authored by Ernest Stefanson, pharmacist, who regrets he is unable to be here this evening as he is in attendance in eastern Canada at the annual conference and annual general meeting of the Manitoba pharmacists' association. So, if I may, I will read Mr. Stefanson's submission to the committee:

My name is Ernest Stefanson, and I am a practising pharmacist in Gimli, Manitoba. I graduated in 1968 from the University of Manitoba and started my own pharmacy in Gimli in January in 1969. I have been actively involved in my profession since then, serving and chairing many pharmacy-related committees. I am past president of the Manitoba Society of Pharmacists and past president of the Canadian Pharmacists Association and also served as chairman of the Pharmasave national board.

When the pharmacy act was passed, and pharmacists were granted the right to approve the regulations, I was delighted. To me, this seemed to be true democracy, when rank-and-file pharmacists get to vote on their regulations. However, this has turned into a disaster. We now have factions of pharmacy fighting to protect and enhance their turf. We no longer are viewed as a united profession, but one that is very fractured. As the infighting continues, the drafting of our regulations is being decided by lawyers and consultants, not pharmacists.

This is similar to what occurred with the Reform Party of Canada. The Reform Party promised that grass-roots members would have a direct line to their member of Parliament in Ottawa, so, quote, their voice would be heard, close quote. As we know, this turned out to be a dismal failure, as the Reform Party attracted every wing nut in the country who thought they knew how to run the country.

A comment I have heard is that pharmacy is a business and therefore should be treated differently from other health professions. I disagree. Most other health professions have a business interest in their practice as well, and they seem well served under the current system. The real responsibility for pharmacists is to elect members to our licensing body who will best serve the interests of Manitobans and the profession.

We, as members, do not need the right to determine the regulations for our act. We need our elected peers to do so, and I, along with many of my colleagues, am comfortable with having our council represent us in this manner. Respectfully submitted, signed Ernest Stefanson, BSc Pharmacy, Gimli, Manitoba.

Madam Chairperson: Thank you very much.

Ms. Oswald: Yes, thank you very much for your comments and for reading the submission today which arguably has the most colourful paragraph we've seen so far. I really appreciate you being here this evening and offering your good counsel on this matter.

Madam Chairperson: Thank you very much, sir. Thank you for attending tonight.

Next I have Jeff Uhl, private citizen. Oh, I'm sorry. I missed a name, and it's not even midnight. Okay, Brian Head. Is Brian Head here?

Mr. Brian Head (Private Citizen): Good evening.

Madam Chairperson: Go ahead whenever you're ready.

Mr. Head: Good evening, Madam Chair, Minister Oswald, other minister, MLAs, and presenters.

My name is Brian Head, a retired educator. I was with the St. James-Assiniboia School Division for 36 years as a teacher and as a principal. I was also the director of an adult education centre. I have been politically active since the age of 14. I was a candidate in the 2003 provincial election under Dr. Gerrard's banner, and I take a keen interest in what goes on in the Legislature.

The Pharmaceutical Act, Bill 41, was passed in early December of '06. This important legislation was seven or more years in preparation with input from all facets of the profession. The intent was to bring the practice of pharmacy into the modern era to address the changes brought about by technology, complexity of medications, the possibility of prescribing, and the changing process of dispensing of medications that occurs, retail, hospital and Internet. The goal was and should continue to be the safety of the public first and foremost.

Bill 41 was passed two and a half years ago, but it has not been proclaimed. The benefits of the legislation have been lost. This protracted delay puts both the public as consumers and the pharmacists at risk. The practice of pharmacy has moved forward to meet the needs of the public but the law and the regulations pertaining to pharmacy have not. Pharmacy practice is ahead of the rules and regulations. This is not good.

Dr. Gerrard put forward 13 amendments to Bill 41, three of which were accepted by the government and the opposition. One of these amendments was that the pharmacist would have the right to vote on the regulations governing their practice. A vote was held, the proposed regulations were defeated. This has resulted in the delay of proclaiming Bill 41. Public safety has taken a back seat.

The internal politics of the Manitoba Society of Pharmacists and the Manitoba Pharmacy Association, as was mentioned several times last evening. The pharmacy profession in Manitoba is definitely a house divided. Differences amongst retail, hospital, long-term care and Internet providers. Public safety on one hand and profitability on the other.

The Minister of Health (Ms. Oswald) used the term acrimony last evening to describe the internal conflict. A suggestion was put forward that a separation might be in order, separating the licensing of pharmacists from the licensing of retail stores. This may very well be beneficial. The degree of bitterness, the destruction of trust, the in-fighting, mass faxing, and mass e-mails, spreading of rumours, lack of professional respect, distinguish the differences. Perhaps a divorce is in order.

***** (19:50)

Last evening, several presenters, lawyers, indicated that about 66 percent of the pharmacists voted down the third draft of the proposed regulations. Sixty-six percent of what? Approximately 500 members of the MPhA exercised their franchise in this very important vote. Again, that is out of a possible 1,200 pharmacists. This means that barely 30 percent of the membership has caused a two-and-a-half-year delay. If pharmacists really cared about voting on regulations, they would have fulfiled their responsibility to vote. Apathy is not a good sign.

I believe that it, that it was Scott Ransome, a lawyer, executive director of MSP, had stated 93 percent of pharmacists surveyed declared that they wanted to retain the right to vote on regulations. I ask how many pharmacists were surveyed? How many responded and were some pharmacists deliberately excluded?

Mr. Harwood-Jones is the executive director of the Manitoba Internet pharmacy association. He is also a lawyer, and I find that an anomaly, that these two groups of pharmacists find it in their best interest to have a lawyer on board 24/7. The MPhA registrar is a pharmacist.

To my knowledge, a second vote on the proposed pharmacy regulations has not been scheduled, compounding the delay, perhaps extending it well into 2010 or beyond. This will be 11 or 12 years from the beginning of the development of the new act; unacceptably long. New, complex medications could be developed in that space of time.

How will the Minister of Health react if the pharmacists vote down the regulations for a second time? I'm quite sure that Minister Oswald will not be amused. Why should the pharmacy profession be singled out for special treatment? The government announced The Regulated Health Professions Act, Bill 18. The intent was to bring all 22 health-care professions under one umbrella; very progressive, very bold and long overdue.

The government's press release stated that transparency and consistency were the appropriate direction to take. Physiotherapists lobbied to retain the right to vote but were refused. Their right was rescinded. Eleven of the professions named in the HPA had the right to vote on regulations, and I believe that has been removed. This is not consistency. Pharmacists have been able to vote on regulations since 1992, but they helped cause the delay, the, the benefits of Bill 41. If provision of greater degree of democracy was a good thing for pharmacists then it should be extended to all, but the fact that representatives from the College of Physicians and Surgeons, the College of Registered Nurses of Manitoba, the College of Registered Psychiatric Nurses of Manitoba, the Manitoba Institute for Patient Safety and the Manitoba Pharmacy Association all spoke against having members vote on the regulations.

Special status for one is counter-productive to the intent of Bill 18. In my opinion, such a move

would complicate the process of changing regulations, perhaps a ball and chain on the Minister of Health, losing some of her ability to act quickly; too many balls up in the air. Political expediency may come into play. All the health-care pro– professions have volunteer organizations. All experience internal divisions. Many have difficulty recruiting active board members. Turmoil will not make this process easier. Getting the majority of members of each profession on board with proposed regulations would be akin to herding cats. If the regulations are passed by the minist–by the membership, the Minister of Health and the Premier (Mr. Doer) are not obligated to accept the results in part or in whole. To me, this reduces the voting and regulations to a hollow victory.

Public safety must always trump business and political interest of health-care organizations. A great deal of thought and collective effort and wide consultation resulted in Bill 41. The necessity of the bill is not in question, but the process certainly is. There are approximately 1,200 pharmacists in Manitoba. The province has approximately 1.3 million so that pharmacists, then, represent approximately 1 percent of the population.

I would like to add that by nature I am a very curious person. Having taught junior high and high school for 18 years trained me to be suspicious. Both characteristics have served me well. I am very suspicious that June 1 and 2 were chosen for these presentations. This coincides with the Canadian pharmaceutical conference in Halifax. A number of pharmacists who would have made oral presentations are not able to do so. Some may have chosen written submissions, others had to request substitute presenters. As a teacher, I know that substitutes have good intentions, but, as a rule, they are less effective.

I sincerely hope that my suspicions are unfounded. I say to you, the government members and the members on the opposition: Stay true to your announced intentions–transparency and consistency. To do otherwise may well result in time delays and unnecessary stress placed upon the volunteer organizations that represent health-care professionals.

This could very well impact on the delivery of quality and timely health care for all Manitobans.

I thank you for having the opportunity to voice my opinions and concerns.

Madam Chairperson: Thank you very much.

The honourable Minister of Health.

An Honourable Member: Yes–

Madam Chairperson: Oh, sorry. The honourable Minister of Health–

An Honourable Member: Sorry.

Ms. Oswald: Yes, Dave. I'm the Minister of Health now.

Madam Chairperson: We travelled back in time for a second, but–

Ms. Oswald: Thank you, Mr. Head, for your presentation this evening, and your, you know, very strong point of view for, for this side of the argument that you declared. I appreciate the points that you're making and again want to reiterate as, as we have said with members of the profession, that of course the ideal is that all professions are, are treated in the same manner, and it's indeed in some cases a marathon not a sprint, and it's my sincere hope that, that, that is the finish line for all of us. And it may take a little longer in places than others, but, but, in the main, I agree with you.

I also want to tell you I, too, taught junior high, so I get what you're saying but want to assure you that there were no sinister underpinnings concerning the scheduling of, of these committee hearings. That had entirely to do with negotiations among House leaders and, you know, party leaders and, you know, I can defer to the House leader to speak to that further if needed, but I do want to assure you that there was no skullduggery afoot. Thank you for being here tonight.

Madam Chairperson: Sorry, Mr. Head, there's more questions.

Mr. Gerrard: Thank you, Brian, for the well-thought-out presentation.

You were commenting about the possibility of separating the regulation over the licensing, you know, of pharmacies as businesses, and we heard earlier on that one of the contentious issue was the use of business incentives, that there points of view on both sides. I think that the businesses generally wanted to have the incentives, and the hospital pharmacists were concerned that this was not in the public interest.

Would, would the separation of licensing allow a separation of that issue from the, the primary issue and help the regulations to be approved?

Floor Comment: Well, not being a pharmacist–

Madam Chairperson: I have to, I have to recognize you before you speak, for *Hansard*.

Mr. Head: Not being a pharmacist but from my own opinion that if the licensing of the retail operations was separated, then the incentives issue, which is contentious, could be dealt with.

Hon. Dave Chomiak (Minister of Justice and Attorney General): I was only going to make the point that, having been one of the House leaders involved in the negotiations for when all of these committees would sit, I can assure you it would have been fantastic if we had the, the ability to actually plan this as well constructed as it could be so that it could be conspiratorial. In no sense of the word was it.

Floor Comment: That's comforting. Thank you.

Madam Chairperson: Thank you very much.

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

Next, I'd like to call Jeff Uhl. Jeff Uhl. Not seeing Mr. Uhl present, his name will drop to the bottom of the list.

***** (20:00)

Next, I will call Don Nazeravich or Nazeravich. I'll keep saying it, and maybe one will be correct.

Welcome, sir. Do you have written material for us?

Mr. Don Nazeravich (Private Citizen): No, I don't.

Madam Chairperson: Okay, you can proceed whenever you're ready.

Mr. Nazeravich: Madam Chair, honourable minister, committee members. I thank you for allowing me to speak to you this evening on Bill 18, the health professions act.

By way of background, I'm a pharmacy manager with the Winnipeg Regional Health Authority and have been a member of the Manitoba Pharmaceutical Association since graduating in 1976. I'm actually–this is rather embarrassing, but I guess I have a confession to make–I'm a substitute presenter. I'm actually here to speak on behalf of my colleague, Lois Cantin, who was registered to speak today, but is currently out of the province. Therefore, I will read from a script that Lois has prepared for me to deliver.

This is what Lois Cantin writes. I would like to thank you for the opportunity to present to you this evening. I'm making my submission as a private citizen, but I'm unable to be in attendance tonight as I'm attending the national conference and board meetings of the Canadian Pharmacists' Association in Halifax.

While I am very pleased with all of the work that is being done on Bill 18, the new Regulated Health Professions Act, I am opposed to the exception of pharmacy in section 210, approval of regulations, which states the regulation does not come into force unless it is approved by the majority of the members.

Before I proceed any further, my professional background is as follows. I'm the Concordia Hospital Pharmacy Manager and Regional Pharmacy Manager of IV Drug Distribution Services for the Winnipeg Regional Health Authority. I was previously regional pharmacy director for NOR-MAN Health Region and I'm also an employee of a community pharmacy. I'm currently a board member of the Canadian Pharmacists' Association. I'm president elect of the Manitoba Branch of the Canadian Society of Hospital Pharmacists, past president of the Manitoba Pharmaceutical Association, past president of the National Association of Pharmacy Regulatory Authorities.

My comments are based on my involvement with pharmacy organizations as well as my work experience. The profession of pharmacy is changing on a national and global level, that is an accepted fact. The status quo is not acceptable and pharmacy is moving towards providing patient-centred care in a manner and under the principles that other health professions do. The Blueprint for Pharmacy document which was developed at a national level by multiple pharmacy organizations has outlined a clear vision and action plan for the future. This document has been, been endorsed by every professional pharmacy organization across the country, including those in our province.

In order to move forward, legislative changes are required. We need the ability to transfer drug distribution activities to technicians. We need the ability for pharmacists to independently carry out patient care in collaborative patient-care settings. We need to be able to carry out the drug distribution activities in the most cost effective and efficient

manner in order to free up pharmacists' resources for patient care activities.

At one point in the development of the new pharmacy act, there were difficulties moving legislation forward because there was no comparable legislation across the country. Back then, we were told that governments do not like to be first. Now other provinces have leapfrogged us with legislation that is either in effect or being developed. We are no longer leader. We're being left far behind.

I recently visited the central compounding facility in Calgary. It is completely run and managed by technicians. The distribution system in my facility, that is the Concordia Hospital, could and should be completely run and managed by technicians, except that because of our current legislation, we have to carry on as a pilot project with pharmacists having to be involved in checking technicians' work. I visited an IV facility in a Middle East country, recently. The entire production is run and managed by technicians.

In order for pharmacists to be patient-care practitioners, we need to be able to delegate non-professional functions to technicians. We need the legislation to enable this. We cannot have the advancement of pharmacy practice guided by business interests or self interests. Pharmacy is not a business. Pharmacy is a profession. Pharmacists graduate from Faculty of Pharmacy with a science degree.

Pharmacists work in a number of different environments, one of which is retail pharmacy. I truly believe that as, as the profession moves forward into patient-centred practice models, the business leaders working with advos–advocacy organizations will continue to develop payment models that will work. There are examples across the country of this happening now. There are models that will incorporate the accessibility to community pharmacists with provision of medications in patient-centred care. This is not going to happen overnight but the legislation needs to be in place to support and enable change to happen at all.

However, for all of these things to happen, the act that governs pharmacy needs to follow the same rules as nursing, dentistry, medicine and the rest of the health professions. If pharmacists are to be treated differently in the health professions act, we will be treated differently on a professional level. It will be much more difficult to proceed as a credible member of a health profession team if we are seen to be ou–if we are seen to be ourselves as a business.

Based on what I have seen happening across the country, what has happened in our province and the direction we need to move forward, I strongly encourage the government to include pharmacy in the health professions act as a profession, equal to other professions, with legislation that is in the best interest of the public good and allows pharmacists to be patient care practitioners equal to all other health-care professionals. Thank you. Respectfully submitted Lois Cantin.

Ms. Oswald: Thank you very much. I thought you were a fine substitute and I appreciate you reading Ms. Cantin's well-crafted argument. It, it's an important part of this discussion as we go forward. Thank you.

Madam Chairperson: Thank you very much.

Next on my list I have Blake Taylor, professor. Is Professor Taylor here? Blake Taylor. He will drop to the bottom of the list.

Next I have Colette Raymond. Welcome back, Ms. Raymond. You can start whenever you're ready.

Ms. Colette Raymond (Private Citizen): Thank you. Madam Chair, honourable minister, members of the committee, thank you for the opportunity to provide input, this time as myself, to the members of this committee as they consider the proposed health professions act.

My comments to you are being provided as a private citizen. I have been a pharmacist since 1998 and I have practised pharmacy in Alberta, Ontario, B.C. but I'm now a Manitoban. I'm a clinical pharmacist. I work in an outpatient clinic with patients who have kidney disease and with a multidisciplinary team of nephrologists, nurses, dieticians, social workers, occupational therapists and translators.

My patients are outpatients. They go to community pharmacies. I call them all the time–community pharmacies that is–and are responsible for taking, getting and understanding their medications all on their own, like most Manitobans.

Bill 41, The Pharmaceutical Act and especially Bill 18, The Regulated Health Professions Act are progressive, well written and clear legislation that advanced the role of pharmacists and pharmacy technicians. I sincerely thank you for these works. I

can't wait for the day that my practice and, more importantly, the practice of all Manitoba pharmacists are allowed to move forward under this legislation. I've been patiently waiting since I was so proud to be a Manitoba pharmacist in 2006 when Bill 41 was passed. I am still waiting.

I strongly support the position that has been expressed by the Canadian Society of Hospital Pharmacists, the Manitoba Pharmaceutical Association, the Faculty of Pharmacy, numerous individual pharmacists as well as supported by the College of Physicians and Surgeons of Manitoba, the College of Registered Nurses of Manitoba, the College of Registered Psychiatric Nurses of Manitoba and the Manitoba institute of patient safety and urge you to consider pharmacy as every other health profession.

I urge you to remove section 210, 211(1) and 211(3) to allow pharmacy to move forward without further delay.

Manitoba, we have drug-related problems and we need more clinical pharmacists.

In 1998 Manitoba spent $232 per person on prescription medications. In 2007 we spent $525 per person. Are we twice as healthy? Probably not. Is all of this drug therapy appropriate? Probably not. Is it causing adverse effects? Absolutely.

Pharmaceuticals represent the second largest and fastest growing health-care expenditure with spending on both prescription and non-prescription drugs reaching nearly $30 billion in Canada in 2008 which is 17.4 percent of total health expenditures in the Canadian institute of health information.

Studies have estimated that 5 to 10 percent of all hospitalizations are medication related as is a large proportion, up to 28 percent, of all emergency department visits. In a recent Canadian study, a quarter of all patients to, of patients admitted to a hospital's internal medicine service were for medication related causes and 70 percent of these were deemed to be preventable.

***** (20:10)

Another Canadian study found that one of every nine emergency department visits was related to medications, again, over two-thirds preventable. The estimated costs of misuse, underuse, and overuse of medications in Canada ranges from 2 to 9 billion per year.

As a clinical pharmacist, I'm very busy. By applying the principles of evidence-based medicine and pharmaceutical care, I make sure that my patients are taking the right drug. Is there evidence for harm or efficacy, both in that patient and in the medical literature? Are they receiving the right drug, the right dose, taking into account their other drugs, organs of elimination, as well as the scientific evidence? Are they receiving drug therapy for all indications? Are they not receiving a drug that they–is unnecessary or causing side effects? Are they receiving the medications as is prescribed? Can they fill the prescription? Do they know how to take it? Do they actually take it? I monitor patients to ensure they're not experiencing adverse reactions, adverse events, or negative consequences. When these happen, I communicate with other members of my team and formulate a plan. I request drug level monitoring; I request lab tests ordering and make dose adjustments.

I provide medication, counselling, and patient education. I determine what patients are actually taking from all of their prescribers, all of their pharmacies, including herbal and natural, and over-the-counter products, and how they're actually taking it, which is often not as they're meant to. I provide advice to physicians regarding drug therapy including doses and alternative drugs. They never ask you about the easy qu–patients. I provide–participate in wellness-related activities, such as smoking cessation or immunization programs, and provide group education to patients.

I also conduct drug-use evaluation and clinical research. Pharmacists' research within the Manitoba Renal Program has saved the Province millions of dollars through evidence-informed formulary management, particularly for high-cost pharmaceuticals. I educate physicians and nurses as well as other pharmacists, and I participate in drug protocol management. Examples of this include anemia management.

These are examples of what I do, but by freeing up pharmacists from dispensing activities, many more pharmacists could practise as I do. There are many examples–in the last page of my handout is references–of the impact that both hospital and community pharmacies–both can–pharmacists can have on patient outcomes. The overall body of evidence in studies and systematic reviews of studies

have shown that pharmacists improve quality of drug therapy, such as adhering to evidence-based guidelines, for example, taking an aspirin a day after a heart attack. Pharmacists reduce undesirable patient outcomes such as hospital readmission, cholesterol levels and exacerbations of heart failure. Pharmacists have been shown to improve quality of life. Pharmacists reduce the incidence of preventable adverse drug events. They have been shown to reduce mortality, drug costs, total costs of care, length of hospital stay, medication errors and rehospitalizations, and pharmacists reduce adverse drug reactions.

The precedent setting Blueprint for Pharmacy calls for optimal drug therapy outcomes for patients through patient centres care as I have described. The Blueprint for Pharmacy calls for pharmacists and pharmacy technicians to practise to the full extent of their knowledge and skills and that both are integral to emerging health-care models to protect the safety, security and integrity of the drug distribution system through the enhanced role of regulated pharmacy technicians and greater automated dispensing to lead to the development and participation in medication safety and quality improvement initiatives. To realize this, the Blueprint for Pharmacy calls for action in five key areas: human resources, education, information and communication, financial viability and sustainability, as well as legislation, regulation, and liability. I would like to address the last of these.

According to the Blueprint for Pharmacy, change cannot occur without support from federal, provincial, and territorial pharmacy regulatory authorities and governments and their commitment to review and amend policies, regulation, or legislation to address and encourage necessary initiatives to just, interdisciplinary, team-based care. As with other health professionals in Canada, regulation is important for protecting the public. The Blueprint for Pharmacy calls for action to address legislation, regulation and liability issues such that pharmacists and technicians practise to the full extent of their knowledge and skills. Proposed key actions outlined in the Blueprint for Pharmacy enact an enabling regulatory framework authorizing pharmacists to deliver expanded services and new practice models, including initiating, modifying, continuing and monitoring therapy, ordering and accessing lab results, administering drugs and vaccines, enacting a regulatory framework that grants more authority, responsibility and accountability to technicians, protect the public through ongoing reconciliation of professional practice.

When asked if the safety, security, and integrity of drug distribution system will continue to be protected through the enhanced role of regulated pharmacy technicians and greater automation of dispensing in a recent Canadian Pharmacists' Association survey, 82 percent of community pharmacists and 92 percent of hospital pharmacists agreed.

Manitoba, we have drug-related problems. We need more clinical pharmacists. We need more pharmacists practising as I do. We need more pharmacists doing pharmacists' jobs and pharmacy technicians doing pharmacy technician jobs.

Consider the health-care costs of not having pharmacists and technicians practising to their full scope. Councils of other provinces are making great strides and, in order for Manitoba to catch up, I urge you to remove section 210, 211(1) and 211(3) to allow pharmacy practice to move forward without delay. Thank you.

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

Ms. Oswald: Yes, thank you, Ms. Raymond. It's nice seeing you again. You win the prize for the most references. I wish there were a prize. I, I thought your presentation was comprehensive, you know, very original and also very compelling. Excuse me.

And, again, I would reiterate that on the issue of, you know, going forward as a profession, you know, we remain open to, to hitting the bull's eye that you, you articulate so beautifully this evening, and, and I, I think you make, you know, excellent points about what a, a terrific benefit that pharmacists are to, to all Manitobans.

So thank you again for being here tonight.

Mr. Gerrard: Thank you, Colette. One of the points that you made, which I think is important and illustrates what pharmacists do, has to do with the clinical research trials that I think you indicate you are involved with in terms of people who have renal problems and may be on dialysis. And, as I understand it, it had to do with the use of erythropoietin and how it was formulated, and maybe you can tell us a little bit more about what you found and why that's got broader applicability in terms of better use of medicines and more cost-effective approaches to health care.

Ms. Raymond: Thanks. I can talk about that no problem. As a pharmacy team, we were sort of tasked with making a–an evidence-informed drug formulator decision. Should the Manitoba Renal Program use one product or another to treat anemia of chronic kidney disease. This is one group of patients, one drug. We spend–I think it's now $9 million per year on this drug. So the uptight pharmacists that monitor everybody's dose, we're busy, and we take it seriously.

And we sought to evaluate if, by comparing our doses on one agent to another after a province-wide pharmacist carried out formulary switch between agents, we would achieve dosing ratios that would lead to cost savings, and indeed we did.

Mr. Gerrard: Yeah. How much were you able to save in terms of dollars province-wide?

Ms. Raymond: We were able to save many dollars.

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

Ms. Raymond: Thank you.

Madam Chairperson: Next I'll call on Danica Lister. You may begin whenever you're ready.

Ms. Danica Lister (Private Citizen): Thank you. Madam Chair, Madam Minister, honourable committee members, ladies and gentlemen, my name is Danica Lister, and I am here today as a private citizen to speak regarding Bill 18.

As background, I've been a licensed pharmacist in Manitoba for eight years. I'm extremely passionate about my profession, and I believe you're getting that sense from those in attendance here tonight. I've been engaged in associations, councils and committees since my early days as a pharmacy student.

In 2006, when Bill 41 was passed, I was the president of a pharmacy advocacy group, and since then I have had a vested interest in and an extreme interest in seeing the wonderful opportunities for practice advancement outlined in Bill 41 come into practice.

I was very excited to see that the progressive aspects of Bill 41 will also carry forward under the proposed umbrella Regulated Health Professions Act, Bill 18, and from both of these acts it is clear to me that this government holds the capabilities and professional practice of pharmacists in high regard and, for that, I do thank you.

***** (20:20)

Additionally, it is clear to me that this legislation has been a great undertaking, and the intent is to provide very clear direction for health professions in Manitoba to be consistent in their governance practices. With consistency among the professions, the public interests will be priority.

As outlined in the explanatory note for Bill 18, each health profession will be regulated by a college whose duty is to serve the public interest. The governing body of a college would be the council, one-third of which would be comprised of public representatives. I feel that this is excellent progress for enhancing the role of the patients and public in health care. This is important for many reasons, including the enhancement of patient safety initiatives.

I believe that increased public representation will also provide health-care professionals with some needed reflection and pause for thought when controversial issues at hand result in delays in implementing new changes.

To my mind, I believe the intent of Bill 18 is to ensure consistency and accountability among the health-care professions. However, there is the notable exception to the consistency outlined in Bill 18, and this under part 15, section 210, 211(1) and 211(3). In these sections, the profession of pharmacy is the sole health-care profession whose college has mandated to pass regulations and code of ethics through its membership. As the committee will be aware, this is the current approach used by pharmacy and since Bill 41 has passed, this process has become an impedance to ensuring Manitoba pharmacists practice in the optimal way to enhance patient care and treatment outcomes. Very many pharmacists have worked very many hours to create regulations for pharmacists that best serve the public. However, no consensus has been reached.

Many efforts continue to be made, the outcomes of which remain to be seen. Bill 41 was passed 30 months ago almost to the day. If the College of Pharmacists of Manitoba would be mandated to continue to follow this approach to enacting regulations, I fear that we may fall far behind our provincial counterparts. I will submit that this current process is impeding our current and future progress as a profession, and I believe that the argument that pharmacists do not want to lose the right to vote, or at pharmacy council would not consult membership if this section was removed, is misinterpretation and misrepresentative.

The current wording of Bill 18 stipulates in part 7, section 82(6) and 83(3), that before making a regulation or adopting a code of ethics, the college must provide a copy to its members for review and comment. This clearly allows for consultative process with members on any matters facing their profession. If this is being adopted by our colleagues in other health professions, I strongly believe that it should apply to pharmacy.

The current Manitoba pharmacy–Pharmaceutical Association would become the college of pharmacists in Manitoba and it elects its council every two years. Every pharmacist licensed in Manitoba has the opportunity either to run to be one of these elected councillors or to cast a vote for whom they would like to represent them. If Bill 18 was amended by omitting section 210, 211(1) and 211(3), pharmacists will continue to have a vote to elect their council and their council will be mandated to consult with them, prior to making a regulation or adopting a code of ethics. Opportunities for feedback would not be lost to pharmacists; they would remain.

The unanswered question that remains, though, is: Would the majority of pharmacists use these opportunities? And history, unfortunately, suggests not.

According to statistics available through the national association of regulatory pharmacy authorities, there are 1,246 licensed pharmacists in Manitoba. This is a large number of professionals who practice in a variety of settings. We had had the right to vote in a regulation for close to 20 years, since around 1992, and in that time there have been several meetings held which provided memberships with opportunity to vote. Looking back at the minutes of various special general meetings convened by pharmacists in the last several years, as available on the NAPRA Web site, in the Manitoba section, it is clear that, unfortunately, these meetings are not well-attended.

While the profession may be engaged in debate and discussion with the Bill 41 regulations at present, the number of pharmacists who take advantage of their option to vote is, unfortunately, underwhelming. And you've heard from others that the draft regulations that went to a first vote in 2008, the regulations were defeated by a 66 to 33 percent majority. But, despite this lively debate and enormous impact that these regulations would have on each and every practising pharmacist, that only represents 40 percent of all pharmacists, and to me that is low. If this is something that is changing the face of your profession for the future and only 40 percent of us show up, that's disappointing.

When the regulations were defeated, one of the arguments presented for defeat of the regulations was that more consultation was needed with the members. So a special general meeting was petitioned by an appropriate number of members, and this took place shortly after the results of the regulations vote. A total of 77 pharmacists voted at this meeting. That is only 6 percent of licensed pharmacists in Manitoba. To me, this begs the question whether the vote on the regulation document was a response to substantial information forwarded back and forth between advocacy groups leading up to the vote, or whether it was due to a true and understood concern by the members regarding the regulation document. Alternatively, it reflects indifference to participation in the process to rectify whatever concerns existed to vote down the document. This poor attendance occurred only weeks after the vote regarding one of the most hotly debated issues in our profession in recent memory. We are not taking advantage of this opportunity to vote, we are not putting more emphasis on the important work of our duly elected council and our opportunity to consult with that council.

I would like to refer to one other special general meeting that was convened in November 2006, just prior to the passage of Bill 41. At that time, membership had questioned the perceived loss of their right to vote, and some argued that our council was not adequately consulting membership. In total, 373 pharmacists attended that meeting, which represents approximately 30 percent of all practising pharmacists. At that special general meeting, the motion put forward was, in essence, to provide an endorsement from pharmacists that Bill 41 represented great change and potential for advancement for our profession. And that motion was passed with 60 percent voting in favour. At that time, the bill did not provide pharmacists with the option to vote on its own regulations, yet, the majority of pharmacists who came to that meeting supported the bill as it was written at that time. This was prior to the amendment that was proposed just prior to the bill passing, and I do think it's important to see that there is precedence that the majority of pharmacists at a relatively well-attended special general meeting supported council's abilities to make regulations with a mandatory consultation process.

Others have argued their point of view that the outcome of that meeting before this committee. I was the seconder to that motion at that meeting, and I believe any discounting of this vote to be unreasonable and dismissive of the preparation and informed pharmacists who attended that meeting for the very purpose of supporting Bill 41. Additionally, I find it unfortunate that there was an amendment brought into Bill 41 in its late stages that was not reflected in the result of the vote that the pharmacists had of its membership.

I would argue that even though this clause is incorporated into Bill 41, this is not a reason to incorporate it into Bill 18. Bill 18 recomen– represents an amazing stride in uniforming all health-care professions to follow the same procedures, and this bill would ensure consistent increased public representation, which is needed in every health profession. In order to ensure that the public representation on the councils of health-care profession, which is one of the most valuable jewels in this bill, we must ensure that their voices cannot be lost or ignored. We must ensure that the decisions made by a professional, elected council, who work innumerable hours to keep apprised of current events facing our respective professions, are held up. Consultation with members will and must occur as outlined in section 82(6). It is up to the advocacy groups to engage their members to use this opportunity but not to impede progress misreporting the actions of council and inducing unfounded concerns.

I would suggest that the process being used at the committee level of the government in Manitoba is one that we could consider. In this process here today, we seated before you have come forward after the first and second readings of Bill 18, to provide our comments to you based on our review. We have been consulted for our opinions and feedback and we offered them to you, and you will now go back and make the final decisions as to the content of this bill. I suspect that after tonight will–you will continue to receive feedback regarding this bill, and we entrust this to you as our elected officials. Not everyone will be happy with the final results of the bill, as was the case for Bill 41, however, we recognize that we have had an opportunity to speak. We also recognize that you represent a large group of people who have elected you, and they have the freedom to vote again for their representatives in the next election. I see that this process, while comprehensive and lengthy, allows for the appropriate amount of consultation with those who are interested and engaged.

I cannot see a system working if you were required to send the aspects of this, and every other bill, to the entire Manitoba voting public for a referendum each and every time. Surely you would not be able to accomplish your ultimate goal to serve the public of Manitoba, and I'm feeling as though–

Madam Chairperson: You, you have 30 seconds remaining.

Ms. Lister: Thank you. I'm feeling as though asking pharmacists to continue with the current status quo of requiring all pharmacists to vote, despite electing a council, is becoming obstructive and nonproductive.

***** (20:30)

I would like to say that the current council that was elected by pharmacists in Manitoba contains a variety of individuals from practice settings like community practice, long-term care, international prescription services, hospital pharmacy, academia and the public. There are liaisons to our council that represent the students of pharmacy, the major pharmacy advocacy groups in Manitoba, and I feel that it is an excellent cross-section of the varied areas of practice that pharmacists would find themselves in. Much like an elected government, any elected group such as council should represent a variety of people and interests, and I believe that current council does.

Madam Chairperson: Your time has expired. Thank you very much.

Ms. Oswald: Thank you very much, Ms. Lister, for being here tonight. Again, a beautifully crafted paper and a beautifully crafted argument. I wonder if some of your teachers are in the audience. They did a great job. Thank you for being here tonight.

Ms. Lister: Thank you.

Madam Chairperson: Thank you very much. Thank you for your presentation.

Next, I'll call Verna Holgate of the College of Licensed Practical Nurses of Manitoba.

Just before you begin, I would–just for all presenters, if you run out of time, we do read your presentations when we have written copies of them. So don't feel the need to rush through. I say that for

our benefit and the benefit of the people in *Hansard* trying to write down everything we say.

So, when ever your ready, Ms. Holgate.

Ms. Verna Holgate (College of Licensed Practical Nurses of Manitoba): Good evening. My name is Verna Holgate. I'm the executive director of the College of Licensed Practical Nurses of Manitoba, better known as CLPNM. I'm a licensed practical nurse that has practiced in Manitoba for over 40 years. With me this evening is the president of the college, Lynn Marks.

As executive director of CLPNM, I've had the privilege of working with the governinmen–government of Manitoba on three pieces of legislation respecting licensed practical nurses in Manitoba and have witnessed both the evolution of the profession of licensed practical nursing and the legislation related to regulatory bodies.

The CLPNM regulates approximately 3,300 registrants, licensed practical nurses, graduate practical nurses and student practical nurses. On behalf of the College of the Licensed Practical Nurse's Board, I'm pleased to provide you with our comments on Bill 18.

The CLPNM Board strongly supports the intent of the health professions legislation and agrees it will provide consistency in the powers and duties that government delegates to regulatory bodies. The board believes that the creation of common legislation related to the regulation of health professions will provide both the public and other stakeholders involved in health-care delivery, with a better understanding of the role and responsibilities of regulatory colleges.

We would also like to acknowledge and thank the Manitoba government for the collaborate approach taken in dev–developing this legislation. And we would also like to express our appreciation to both Barb Millar and Heather McLaren for their assistance, support and guidance during the discussions and review of the various drafts related to the reserved acts and the complaints and discipline process.

The CLPNM Board was pleased to be part of the consultative process for the discussion paper and was pleased to see that many of our comments were considered in the drafting of Bill 18. Overall, I can tell you that the board is pleased and supportive of the proposed legislation.

Our comments tonight are brief and are related to three specific areas of the legislation: public representatives, the Health Professions Advisory Council and regulation governance.

The first area is in related to section 13(2), appointment of public representatives to council. Under the current Licensed Practical Nurses Act, the CLPNM uses a public representative committee to make public appointments to the boa–both the board and committees of the college. The board believes that this has worked well for the college, however, we do support a shared responsibility in making public appointments to council and, therefore, recommend that the legislation should be amended to reflect that 50 percent of the public representatives be appointed by the minister and the other 50 percent through the CLPNM's public representative committee.

The second area is the Health Professions Advisory Council. The board does not support the exclusion of regulated health professions from the membership of the council and urges that this exclusion be reconsidered. Based on the mandate of the council, we strongly believe that the expertise that health regulators would bring to the table would be an asset to the functioning of the council. We also believe inclusion of health regulators at this table would carry forward and maintain the collaborative partnership we have established during the creation of this act.

CLPNM believes that there should be a balance of professions and other representatives. For example, we support the composition of council being seven and we would recommend that three of those members should be appointed from regulated health professions. Currently, the regulated health professions in Manitoba have established a network, and we believe that nominations to the advisory council could be made through that group.

Our last comment is in relation to governance and the Manitoba government's goal to harmonize the powers and duties delegated to regulatory bodies–harmonized legislation which is clear, workable and effective in regulating health professions in the public interest. Therefore, the board of CLPNM believes that the regulatory authority for the approval of regulations should be consistent for all regulatory colleges, including the College of Pharmacists.

In closing, we would like to thank you for giving the CLPNM the opportunity to comment on Bill 18 and look forward to maintaining a collaborative working relationship as we move forward with the implementation of the new, regulated health professions act which supports the role and mandate of regulatory bodies while strengthening public accountability and public protection.

Madam Chairperson: Thank you very much.

Ms. Oswald: Yes, thank you very much, Ms. Holgate, for being here tonight and providing this presentation. I thank you for acknowledging the individuals that have dedicated their hearts and souls into this for many years, and I'm very glad that you raised the issue of the representation, the 50 percent representation. It came up last night, and I neglected to mention at that time and wanted to provide you with the comfort, of course, that there is no intent to change. The act allows for this to continue for the colleges that have this. LPNs and RNs fit into that group, and so you will be permitted to continue in that vein.

Secondly, on the issue of the advisory council, one of my colleagues last evening–you raised a good question about compiling an advisory council from 22 professions and having representation from them all and the potential problems with that, and that was raised as a suggestion during the consultation. And it's reflected in the act that this advisory council is compelled to consult with the profession on matters that concerns them. So I want to offer that comfort to you as well.

Thank you again for being here.

Mr. Gerrard: Thank you and let me come back to the advisory council issue, and the–there's the concept, right, which you're supporting, which is that the advisory council should include members of the regulated professions–certainly has benefit in making sure that the ideas coming from the professions have a way of those ideas flowing through to the council in an effective way.

I suspect that there's also a concern that, if you have public representatives and members of the regulated professions, that the regulated professions because of their, sort of, inside information may dominate what happens at the council and that there would be a concern that the public people on the council would not have as much input. So maybe why don't you give us another comment and the reasons for your supporting this so strongly.

Floor Comment: I really believe–

Madam Chairperson: I'm sorry. I have to just recognize you first.

Ms. Holgate: The board of the College of Licensed Practical Nurses strongly believes that the expertise of health regulated professions would be a valuable asset to the council when you're looking at what the mandate of the council was.

We also believe that there should be a balanced representation, and so what we're suggesting is that there should be some representation, but, as we suggested, that the majority of the members would be the public representatives and not overbalanced by health-regulated professions.

***** (20:40)

Mrs. Myrna Driedger (Charleswood): Thank you, Mrs. Holgate. A question in regards to the advisory council: What kind of process could be put in place, considering there are 22 health professions that come under this legislation? What kind of a process would you recommend in order to have some representation on an advisory council? Do your registrars meet on a regular basis? Could, could that be a opportunity to, you know, I suppose, take turns or, or make recommendations or nominate somebody? Like, what–how would it work?

Floor Comment: Yeah, as I indicated in my–

Madam Chairperson: Sorry. Ms. Holgate.

Ms. Holgate: As I indicated in the presentation, what we're suggesting is that the regulated health professions have a network that meets on a regular basis to discuss common issues regarding regulatory matters, and we are suggesting that that group could be used to make nominations and put forward to sit on that advisory council.

Madam Chairperson: Thank you very much. Thank you for your presentation.

Next, I'll call David Wayne Rivers from Procurity Inc. Do you have any written presentations? They are coming, great. You can start whenever you're ready, sir.

Mr. Wayne Rivers (Procurity Inc.): Madam Chair, Madam Minister, members of the committee. Good evening and thank you for hearing my deputation this evening.

I'm Wayne Rivers, president and CEO of Procurity, a pharmacist-owned distributor of everything you find in a drugstore from tinned tuna to narcotics. Procurity used to be called United Pharmacists and was your classic co-operative that offered independent pharmacists the buying power needed to compete with chains. Today, we are owned by about 115 independent pharmacists representing roughly 40 percent of Manitoba's community pharmacies. I would hazard to guess that there's at least one Procurity store in each of your constituencies, possibly more if you're from a rural or northern community.

I know that many pharmacists have or will be making deputations on this bill, and it's not my interest to occupy any more of your time than necessary. Frankly, I find the amount of oxygen spent on section 210 and 211 disproportionate to their magnitude in the overall scheme of things and applaud the committee for its patience.

In the interest of full disclosure, I must confess that even though I've worked within the community pharmacy sector for decades, I am not myself a pharmacist and, while I'm not a member of the profession, I've made it my business to keep apprised of trends affecting the profession and the business of pharmacy.

When I first entered the pharmacy sector over 30 years ago, there was a clear understanding as to what was expected of a pharmacist, and that was pretty much reserved to the lick, stick and pour activities that we're all familiar with. Then, about 15 years ago, so-called drugs by design starting hitting the shelves, treating such things as ulcers, hypertension, cholesterol, depression, et cetera, and about the same time, we baby boomers started getting older, and pretty soon, there was an explosion on our hands. Pharmacists were being called on to be drug experts to a patient population that was taking more and more drugs. Not coincidentally, pharmacists became more active champions for their profession and started to assert themselves politically, demanding broader scopes of practice. Lick, stick and pour just wasn't going to cut it any more.

A couple of years ago, during The Pharmaceutical Act debate, community pharmacists came to the view that the MPhA was captive to the academic and hospital sectors of pharmacy and was largely indifferent to the realities facing community practice. This view was reinforced by the fact that MPhA presidents have been, for four successive terms, drawn from hospital pharmacy. Putting that in context, community pharmacists make up about 73 percent of practising pharmacists in Manitoba, hospital pharmacists, about 22 percent.

Let me be the first to say that it's not lost on anyone that the MPhA exists to protect the public, and that's not in dispute, but I will say that it is the expectation of my shareholders that their self-regulatory body be roughly representative of the profession it governs. The MPhA's first attempt to secure the approval of its membership for the new set of regulations to accompany the new pharmaceutical act failed spectacularly: 168 for, 322 against and 113 spoiled ballots. The vote was more an indictment of process rather than substance. Many of Procurity shareholder pharmacists were sending a signal to the MPhA that more consultation is needed.

Does community pharmacy blend a commercial and medical ambition? Sure it does, and it always has. What's different now, and what MPhA has to reflect is that community pharmacy wants regulations that reflect the reality of the practice setting and not some unworkable, theoretical rules that prevent them from serving their patients and communities.

Our members work on the front line of care and are especially valued in rural and remote communities. I am proud to work with a profession that never compromises patient care, even when we suffered from a shortage of pharmacists.

My shareholders believe that a member vote to approve proposed regulations, which are then subject to final approval by the Lieutenant-Governor-in-Council, makes for better policy, and I applaud the government for making accommodations in Bill 18 to preserve the voting rights of pharmacists.

In the context of pharmacy governance in Manitoba at this time, the vote has become a very important mechanism to ensure that pharmacists have a voice and can participate fully in the current and future governance of their profession. I am encouraged that those who were called on to participate in the PricewaterhouseCoopers' exercise did so in good faith, and with an eye to developing and passing the best regulatory package available.

Madam Chair, I thank you and your committee for your attention, and I welcome any questions, should there be any.

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

Ms. Oswald: Thank you.

Just a, a quick comment. I appreciate your points of view presented in this paper, appreciate that you come to this debate as, as part of pharmacy and yet not a pharmacist. I think that's an, an interesting voice to come to this, and I thank you for being here tonight.

Mrs. Driedger: Thank you, Mr. Rivers.

Two questions: were you surprised that this bill was brought forward before the PricewaterhouseCoopers' report was completed, which I understand it's supposed to be completed this month? And do you think the government should have brought in a consultant or a mediator sooner than they did in order to help some of this divisiveness that we're seeing within the pharmacy profession?

And, could we have avoided a lot of the problems that are out there right now and that have been inflamed quite a bit over the last number of years? Would a consultant or a mediator in a more timely manner have helped to resolve some of this?

Floor Comment: That's three questions.

Madam Chairperson: I just have to recognize you before you speak, Mr. Rivers.

Mr. Rivers: My, my comment would be that my, my long experience in business has told me that hindsight is always 20-20 vision, and to address the first part: was I surprised th–that the bill came forward now? No. I mean, there's 22 professions in question here. I wouldn't expect that any one would, would be in place to hold up a, a process of a bill of this magnitude.

As far as the PricewaterhouseCoopers report, I understand it's expected–you're correct–at the end of this month or, or early into July. Should it have happened sooner? As I say, hindsight's always 20-20. I think that what is encouraging is that there's effort being made to bring the fractious parties together. I think that is, I think that's what's key to the whole process. I think, optimistically, I think people are looking for good recommendations from that report.

Madam Chairperson: Thank you very much.

Mr. Gerrard: Thank you for your presentation, and just from your perspective, do you feel that the PricewaterhouseCoopers' process that people are close–are people close enough together that we're gonna get a solution?

Mr. Rivers: I haven't, I haven't been part of that or involved in that, in that process. I'm, I'm hopeful that the, the various parties have been engaged. I'm hoping that there's some candid recommendations from that report because, clearly, there's a need to, to bring pharmacy together. I mean, there's a disconnect here, and that needs to be overcome.

As like everyone else, we're, we're hopeful that there'll be some good work come from that.

Madam Chairperson: Thank you very much. Thank you for your presentation.

Two of the presenters who had registered are from out of town. So, I'd ask the committee's leave to go to those two presenters now, as per our previous agreement. The first of which is Doug Penner.

Thank you very much, Mr. Penner. You can start whenever you're ready.

Mr. Doug Penner (Private Citizen): Sure. Thank you. I just wish to thank all of you and distinguished memb–members of this committee for giving me the opportunity to speak.

I don't have anything prepared, and I'm not overly eloquent. But, don't hold that against my teachers. The–and I would refer to former speakers, specifically Mr. McFeetors, to express my concerns and opinions regarding Bill 18 and, specifically, Bill 41–aspects of it.

***** (20:50)

What I would just like to say, I am a–my name is Doug Penner and I'm a pharmacist in Manitoba. I've been a pharmacist for 16 years now. I belong to the Manitoba Pharmaceutical Association. I am not a teacher. I'm not a lawyer. I'm not a substitute. I'm not a director. I'm not a manager. I'm a run-of-the-mill pharmacist and I hold that, or I say that with distinction. I'm proud to say what I do and I'm proud of the results that I achieve.

I work in hospital pharmacy, specifically, in rural Manitoba, in the North Eastman Regional Health Authority. I service the pharmaceutical services of three rural hospitals, and I believe I do the job, not only to the best of my ability, but I also believe I do a very good job. I do that very good job under the, under the auspices or under the governance of our existing Pharmaceutical Act. I have to say I don't believe I need a new act or

specific details in a new act to make my work superior or make what I do more beneficial to people or to make me more satisfied in my job.

I would also like to say that I do take certain offence to some of the things that I've heard of while sitting here and listening to the discussions. I take offence to the fact that somehow people of the public, non-pharmacists and pharmacists alike, have this idea that somehow what I do is antiquated. What I do is top-of-the-line, top-notch health care. I protect health and save lives every day. I'm a front-line health-care worker, and, again, to change a bill or to modify a bill or to take away my rights to vote would not enhance that in my opinion at all.

I find it somewhat ironic and somewhat scary that in these hallowed halls of democracy, I'm asking this distinguished committee to reject any notion of reversing a pharmacist's longstanding, tried and true, ability to vote for regulations and codes of ethics. I think it's even more ironic and even more disturbing that I'm asking this, again, this committee, who fully understands and appreciates the value of democracy. That is what is the attempt to do.

I also take objection to the fact that it's been mentioned that the Manitoba Pharmaceutical Association, we ought to rely on and hold confidence that they will perform, as some expect them to perform, under the new or the proposed Bill 41, whereby the change of having no vote. I'm very concerned about that. I've seen our, our Manitoba Pharmaceutical Association under numerous councils behave in rather concerning ways to me, just a Joe Schmo member.

I can just recently think of a special meeting that was called–that I think Dr. Gerrard was even in attendance of–whereby we were asked to come and discuss Bill 41 changes, and as soon as the floor was opened, it was organized that the first motion was to stop all questions, which was passed, and all questions were then stopped. This is the type of council that I don't really feel trustworthy to carry the concerns of the pharmacists' members and also the safety of the pharma–for the general public at hand.

I take objection to some of the concern–or some of the issues raised, whereby the eclectic nature of the pharmaceutical council makeup is, is an excellent provider of, of broad judgement and different opinion. My counter to that would be, I'd rather have 1,200 members make those patient safety decisions than just a few members on it; at least, if anything, to dilute bias.

I also take exception to the fact, where the MPhA, instead of acknowledging issues and problems in the current Bill 41, as it stands, and to proceed with consultation and modification, work in opportunistic ways to go through somewhat backdoor channels to change a situation. Instead of saying the bill's flawed, it's the voting process that's flawed. Again, we have 1,200 members that each had the dual right–duly-appointed right to vote. Those that wanted to consider to do that vote, they did vote, they spoke, and council should accept that and then go forward to create or to discover what the issues were and to make those changes. I've not seen that as a, just a general member.

The–I think the–what should be done or could be done is that the current Bill 18 as it's written is, I think, drafted in a proper way, drafted for the protection of the public. I think Bill 40–the current membership vote hasn't hindered Bill 41, hasn't, or in terms of the hindered for the practice of pharmacy. It's my opinion that the current delay or hold up or request for Bill 41 changes to take place has actually protected the public, and I'm glad to see that that's democracy. That's our system in pharmacy working perfectly to this day, and, until some of those changes are made, I would expect, then, that we should still have this impasse. And that's again part of the democra–democratic system that we are involved in, and we're still waiting for negotiations to take place.

I have other objections, but I don't really–it's late in the day and I don't really need to rehash the same old things again, so that's all I have to say.

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

Ms. Oswald: Yes. Thank you very much, Mr. Penner, for being here and sharing your point of view on the issue. And let the record reflect I don't think there's anything runamill, run-of-the-mill about you. Thank you for coming.

Madam Chairperson: Thank you very much, sir.

We have an additional presenter who's also from out of town, so I'll call upon him now. That's Elmer Kuber.

Mr. Elmer Kuber (Private Citizen): I thank you very much. I'm really from out of town because I just got off the plane from Halifax, so if I feel a little

groggy, it's almost 11 o'clock my time. I just got back from the Canadian Pharmacists Association annual, annual meeting.

Good evening. My name is Elmer Kuber, and I wish to make a presentation as a private citizen in support of Bill 18 as it currently is written.

By way of background, I've been a pharmacist for more than 35 years. I graduated Temple University in Philadelphia in 1972, so that explains my accent. I completed a University of Toronto hospital pharmacy residency in Ottawa. I have a master's in health administration from University of Ottawa and PharmD. I've worked in community pharmacy, hospital pharmacy, long-term care. I'm semi-retired, and I'm a part-time grandpa, and part time I work at the community pharmacy in Stonewall, Manitoba. What the bio doesn't say, I spent 20 years about, approximately, outside the profession in health administration. And Mr. Chomiak knows me from my days when I was, I was CEO of the Selkirk General Hospital for about 13 years. And I chaired an ambulance legislation review committee at some point in time, and they're reviewing the act again, so time flies.

I was elected to the Canadian Pharmacists Association board as a Manitoba representative in 2001, and actually, this morning, I just came off the board after eight years. Part of that time, I was vice-president in 2004 and 2005. And I'm also current vice-president of the Manitoba Society of Pharmacists. Some people say I'm the last, one of the last, volunteers.

I just returned this evening from CPhA in Halifax. The Canadian pharmacists had their annual general meeting this morning. I can tell you first-hand that a good portion of the discussion was spent on the challenges related to pharmacists being fractured and segmented, and, if I have time at the end of this presentation, I'd like to review my day of encounters with pharmacists, if I can.

It's not simply a Manitoba phenomenon. There is a clear need to come together, and I assure you that here in Manitoba, Society of Pharmacists wants nothing more and will have recommendations on how to accomplish this goal in the hands of government in the foreseeable future. I understand that there has been a disportionate number of publicly funded university and regional health authority pharmacists making presidents to the committee over the past two days. Given that community pharmacists represent 73 percent of all pharmacists, it would have been effortless to bring out increased numbers to these hearings. However, a parade of pharmacists reacting to the same message is hardly a useful exercise.

I understand you have already received from the society's executive director, Scott Ransome, the Probe Research finding, which indicates that 93 percent of those pharmacists polled want to retain their ability to vote. I would like to–I would like to present a different finding from the Probe Research survey.

***** (21:00)

As you will know from the attached information, when the following was put to them, the Manitoba Pharmaceutical Association has recently asked the provincial government to remove the clause to vote on changes in regulations affecting their profession. Do you personally agree or disagree with this position? Eighty-three percent disagreed with MPhA and only 12 percent agreed. Based on what I'm told has gone on at this committee over the past two nights, it appears that all 12 percent have appeared at the committee.

I would also like to address any confusion with respect to the Manitoba Society of Pharmacists' commitment to an expanded role for both pharmacists and pharmacy technicians. One of the society's main concerns with the draft regulations, which were defeated, was not a fear of change but that there was not enough change. The draft regulations lacked ambition. Pharmacists are able to provide much more than the draft regulations contemplated.

During my time as vice president of the Canadian Pharmacists Association, we took a leadership role in developing, as part of the Blueprint for Pharmacy: Vision for Pharmacy. The blueprint has the support of pharmacy organizations across Canada, including the Manitoba Society of Pharmacists. In fact, the president of MSP, Mel Baxter, has–he was a committed member to one of the national committees charged with implementing the Vision for Pharmacy.

At this time I would like to briefly review the vision of pharmacy. The vision of pharmacy is optimal drug therapy outcomes for Canadians through a patient-centered care. To reach this vision, the following must occur: one, pharmacists and pharmacy technicians must practise to the full extent of their knowledge and skills and are integral to

emerging health-care models; protect safety, security, integrity of drug distribution system through enhanced role of regulatory–regulated pharmacy technicians and greater automation of dispensing; lead the development of, and participate in, safety and quality improvement initiatives.

Pharmacists manage drug therapy in collaboration with patients, caregivers and other health providers; identify medication use issues; take responsibility for drug therapy decisions and monitor outcomes; initiate, modify, and continue drug therapy through collaborative arrangements, delegated or prescriptive authority, and order tests; access and document relevant patient care information, health records, including test results and treatment indications, electronic health records; empower patients in decision making about health and play a prominent role in health promotion, disease prevention, and chronic disease management; conduct practice research and contribute to evidence-based health-care policy and best practices in health care. Pharmacists' services are compensated in the manner that relates to expertise and complexity of care.

In closing, I would just like to review my day. I started out, Halifax time, waking up at 7:30 this morning. So that's 5:30 our time; that's why I apologize for not being too closely shaven. We had our annual meeting this morning where I and chairman of the association of the affairs committee did a boring addition to the bylaws, but in any event afterwards without having any real solutions we had discussion. And we had a pharmacist from Newfoundland get up because we had a presenter talk about advanced clinical care. She was a university professor from University of Minnesota, and she really knocked community pharmacy, badly, in the thing as well.

It seems to be a common thing–theme lately and this pharmacist got up. He had been a pharmacist in Newfoundland for over 40 years and he was in tears. And he said, look, you know, there's all this division in profession. It's not only here. It's, like, in Newfoundland. It's across the country, and he gave examples of community pharmacists in Newfoundland and how they've gone the extra mile and how somebody set up stores in remote areas where it wasn't even profitable just to do so. And he was literally in tears.

We had a real heated discussion this morning about the value of community pharmacy. I had a lunch break, and a member, a former member of the board of directors of the Ontario Pharmacists Association came to me, and he shook my hand and then he hugged me and he was almost in tears. And I said, what's the matter? And he said, you guys in Manitoba are the only ones who are sticking up for democracy. He said in Ontario we're living in a dictatorship. We have no input to our college. We have no input to regulations. We've all made a mistake about giving up voting rights, and I wish, I wish we, we hadn't done that, and keep up the fight and hopefully maybe you can set a precedent for us.

I changed planes in Toronto. I ran into a, a Shoppers Drug Mart associate from Winnipeg who I know, know well, and I just asked him, what do you think about voting rights? And he said, I don't want to give them up. He said, I can't believe it's even being contemplated.

I got off the airport–out of the airplane, and I'll confess, I was hungry. The cheapest place between here and the airport to, to eat lunch is, or have a quick bite to eat is the hotdog stand at Costco. So I went there and I went to the pharmacist there, and I said to them–they even said I could use my name, and I said, what do you think of voting rights? And their exact remarks were like about giving up voting rights and the pharmacists said to me, are you nuts? What are we gonna be asked for next? To give up a right of vote in provincial elections. That was his exact words to me a half hour ago.

So I leave you with that. I thank you, thank you with that, and thank you very much. I don't–do I have, can I have 30 seconds to get just a little personal 'cause I really–while I've got Dave here–I would just, off the record, like to thank him for something.

Dave, you never know what you do at times and what has meaning, but when I was here once for a Holocaust memorial service, and I was there with my daughter who was this big, and we came back in and we were trying to get in. I was going to give her a tour of the Leg and the doors were locked–and you probably don't even remember this–but you opened the doors and illegally and let us in and let us tour the thing. She, she remembers that to this day, Dave, and, and tomorrow or Thursday, University of Mani–Winnipeg she graduates with her second degree with a B.Ed. But she still remembers that. So you never realize what little things you do for people, but it makes a lot–and I'll gladly answer any questions.

Madam Chairperson: Thank you very much.

Ms. Oswald: Thank you very much for your compelling presentation and, and your real-life journey today, and I hope it continues safely home tonight. Thank you for being here to add to the conversation. Thanks.

Mrs. Driedger: Thank you very much for the presentation tonight, Mr. Kuber.

I have a question related to pharmacy technicians in community pharmacies. Are they utilized significantly or how prevalent would they be in community pharmacies and, I guess, what is the view of community pharmacies towards using pharmacy technicians?

Mr. Kuber: I, I, I think it varies all over the map, but I've never worked in a pharmacy from the time I–I spent my first day in a drug store in 1966, and we had helpers there that were basically doing the roles of technicians, and in those days we called them pharmacy clerks or pharmacy aids. I think every store or every, every community pharmacy utilizes technicians whether they're store trained or formally trained in different matters depending on the comfort level of the pharmacist, and it runs the gambit. I've worked in stores where in communities, in Selkirk, for example, when I worked in Selkirk, where the–where the pharmacy technicians did meter instruction and did, did full diabetes instruction because it just so happened that one of the technician's husband was a severe diabetic and she would really knew it better than any of us did, so she did, she did the meter instruction. So I think you go with your strengths.

I think, in a regulated process where we have defined roles and responsibilities, I think that that'll, that'll certainly improve the role of the technician and make it more consistent, and then it's–some, some pharmacists, especially older ones, may not be comfortable with regulated technicians and it may take awhile for that to phase in. You know, but I honestly believe it's, it's certainly the way to go.

We–the presentation that I referred to from the professor from University of Minnesota even kicked the blueprint up a notch and I had introduced her, I chaired the luncheon session yesterday, and she asked me, she said, you know, can I provoke discussion? And I said that I–I've seen that new TV series *The Mentalist* and I've said, from your body language, I think you're going to do more than that–that wasn't my words, but I won't use those words here. And she said, yeah. She said I'm really going to stimulate them, and she was very good about even, even pooh-poohing certain things on the blueprint not going far enough and saying that pharmacists really had to take it an even further role in clinical care.

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

Next, I will call on Mark Scott. Welcome Mr. Scott.

Mr. Mark Scott (Private Citizen): Thank you for letting me speak. I'm a pharmacist and business owner, and I am for keeping the voting rights of pharmacists.

What I heard tonight that it is because of pharmacists that regulations got voted down. I have to disagree. There has been one vote on the regulations which got defeated. Pharmacists voted only once. So instead of trying to work with people to try to solve these problems, the seven issues that were a problem, the MPhA has decided well, it's probably easier for us to get rid of the vote instead of working with the seven problems.

Before the vote on the regulations that got defeated last year, in 2006–whenever, or a couple of years ago–there were several groups that made suggestions for changes that had nothing to do with patient safety. I've heard tonight that it's about patient safety and business objectives are different. That's not true. As a business owner I will not jeopardize patient safety and, as a pharmacist, I am all for patient safety. That does not mean I can't make money or profit on, on pharmacy. Those haven't–they're one in the same. Patient safety, I want to make sure the patients are safe. That, that is irrelevant.

***** (21:10)

The reason that regulation got voted down was because the MPhA refused to make–take–the suggestions and work with the people to fine tune the regulations before they were sent to vote. Since that vote, there were subcommittees that were formed to work on addressing these problems. It is my understanding that these problems have been pretty much worked out, if not all of them have been worked out, in that the regulations should be ready for a second vote, which I hope will pass. I'm not sure when this will happen, as I've not heard, but I think these new and improved amended regulations will be best for pharmacy, and this is why we need to keep the vote.

That's all I have.

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

Ms. Oswald: Thank you, Mr. Scott, for being here tonight to present your point of view. We appreciate it.

Madam Chairperson: Thank you very much. Next, Brent Penner.

Mr. Brent Penner (Private Citizen): Good evening, everyone. I'm a bit of a small fish in a big pond because I'm not used to speaking to such a distinguished committee. Bill Blaikie in front of me; okay, that's quite impressive. There's so many times I've been watching the CBC and you're on the TV, and for me now to be in that position–ha, I'm going to have my drink of water first, actually. This is almost like question period, so give me a second here.

Okay, as it's pretty obvious, I'm a pretty humble pharmacist here. I'm a pharmacy owner as well, and, just like the previous said, I should probably stick to my notes, but this will be a mistake I will have to deal with later. Like he said, we've heard so much about how pharmacy and business are not related. Well, I'm going to say that's completely wrong. Hospitals are a business. Yes, they work on bidgit–budgets, but at the same time, they have to control costs; they think like businesses. Independent pharmacies are businesses, of course. If, if pharmacy fails as a business then there's going to be less access for the public to obtain medication and resources of the pharmacy. So I just wanted to get that beef out first. Today, though–back to notes–I'll probably go back and forth–I stand here appalled, amazed, and mostly confused as to how–why, why, how and why my peers of this very same profession have a completely different opinion of the basic but most important right of being able to vote.

I'm here today as a small import retail pharmacist–probably said that already–trying to preserve my voice, my right, to have a say on important matters like regulations–going off topic here a bit. I almost am slightly offended–I'm offended–how other professions, nursing, can come in and say, well, I think this is best for pharmacy. We're completely different professions. Yes, we work with people; yes, we're in health care, but the, but the fundamentals of how we work is very different. I don't perform nursing services and I don't think nurses provide pharmacy services. Very, very different. To think–and as a small, independent business owner, I don't have a big banner or big lobbyist group defending my rights. It's me here in front of the mike in front of you people. I don't have any strong unions that pound saying we need this, we need that. It's me in front of you, Bill Blaikie.

So I, so I do cherish the opportunity of coming to the meetings to vote. The current voting process has served pharmacy profession well over the past decades. To speak to the idea that giving individuals the ability to vote on decisions that shape our–my profession is flawed makes no sense to me. The opportunity to have 1,200 pharmacists vote on an important pharmacy matter compared to a very small number of council members assumes both the best–assures both the best decision is made with effect to both public safety as well, the pharmacy workplace as a whole.

Their argument is only strengthened when I recognize how multifaceted the profession of pharmacy is with so many different members working in so many different workplaces doing so many different tasks on a daily basis. All members from all areas need to be able to vote on the workplace that we all work in. Giving all members the ability to vote ensures the best decisions for all members are made. Decisions made with the input of many prevents quick changes from being made that cater to a select few. I've heard the complaint that the ability to have the individual pharmacists vote on important issues such as regulations has slowed down the process of them being approved. But a very common expression in pharmacy that all pharmacists have said many, many times, usually to themselves is, when you see this aggravated customer, do you want it right, or do you want it right now? And to me, it's more important that we get it right than right now. This whole nonsense that's being said is the fact that we need to hurry up and get this done because patient safety's at risk. I find that insulting because I do not, every day, when I work my 10 hours every day, put my patients' risk–patients' safety at risk by coming to work, working under the current regulations. That's completely garbage. I don't even know where they get it, you know, come up with that. I only believe that the input of many can ensure that the right decisions are made, and that's what I have to say. Thank you.

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

Ms. Oswald: Yes, thank you, Mr. Penner, and I appreciate you coming tonight to share your point of view. And Mr. Blaikie has the same effect on me.

Floor Comment: I know.

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

Next, I have Curtis Unfried from the Manitoba International Pharmacists Association.

Do you have any written material for us?

Mr. Curtis Unfried (Manitoba International Pharmacists Association): I do not.

Madam Chairperson: You may start whenever you're ready, sir.

Mr. Unfried: Yes, thank you.

Good evening, honourable Madam Minister, Madam Chair and honourable members of this committee. I, too, would like to thank you for giving me the opportunity to address you this evening. Candidly, I had not intended to make a presentation in this matter. However, having had the benefit of sitting through the presentations last night and as well as they're here this evening, I thought that I could provide some additional information and background for your, for your consideration.

Much to the chagrin of Mr. Head and perhaps others in the room, I, too, am a lawyer. I am, more specifically, legal counsel to the Manitoba International Pharmacists Association, and as you may recall from Mr. Harwood-Jones' presentation last night, MIPA, as it's also known, represents the interests of the International Prescription Service Pharmacies, which are often somewhat inaccurately referred to as the Internet pharmacies.

I don't intend to repeat what Mr. Harwood-Jones said to you yesterday; however, what is apparent, as you've already heard, is that the issue of the voting rights of the members is central to the pharmacy members in the MPhA. Obviously, there are differing views of that, but I am here this evening to speak on behalf of the members of MIPA to reiterate the importance of their voting rights to them.

Many of those that have presented in opposition to the voting rights have indicated to you that the– there's an internal conflict between the commercial rights of the pharmacist and their obligations to their patients. I would submit to you that, based on the presentations made to you, there is no hard evidence that, in fact, that is actually the case. What you have heard, for the most part, are hypotheticals and possibilities, but, again, I would urge you to look at the presentations. There is noth–no actual evidence of that actually occurring.

Others have said, in effect, what's the big deal? You know, look at all the other health professions out there. They don't have their voting rights. What's the difference with pharmacy?

Madam Vice-Chairperson in the Chair

I think what's clear is that there has been a historical dysfunction and a clear distrust of the council of the MPhA, and that is the difference. Having said that, I do want to take the mo–this opportunity to pause to say that the MPhA and its council has made many positive strides over the last approximately 15 months, in particular, after the defeat of the regulations. You've already heard of the Pricewaterhouse proposal that's ongoing. There was also a retreat. There's also many subcommittees that have been struck to review the issues of, in effect, what went wrong. Why were the regulations defeated? And, again, the MPhA should be commended for doing that, but I would submit that the, that the defeat of the regulations actually spurred these many positive changes in that I think the MPhA and its council realized that things had to be done in a different manner to address the concerns of their members.

Many have suggested in support of removing the voter's rights that, in effect, council should be trusted, in effect, that they can be–you know, they will have consultations with the members and that that will be sufficient. Unfortunately, given the recent history of the MPhA, those assurances ring hollow among many of its members, including the members of my association.

Mr. Harwood-Jones has touched on that history already. But, quickly, in 2001, there were two related motions in which the council was seeking to remove the voting rights of members. Those were defeated. About eight months after that defeat, the council went ahead and introduced a, a challenge to the Minister of Health to change the regulations, despite not having any mandate from its members. The effect of that proposed regulation, if it had been implemented, would have put IPS pharmacies out of business.

After a petition was signed by the members calling for a special general meeting, the MPhA backed away and, in effect, clarified their position

saying, look, we were only challenging the minister to bring in the regulation, but we recognize that ultimately it would have to go to a member vote.

***** (21:20)

Then, in October 2002, the MPhA brought in licensing requirements for the new licensing applications. The effect of those would have been to put IPS out of business. Our association filed a court application to challenge that. That resulted in a–what some of you may remember as the Wally Fox-Decent mediation, and that resolved the contentious issues that were faced by our members then.

Fast forward to 2006, Bill 41's introduced, and again, the voting rights of the members are removed. There's been reference to the November special general meeting. Again, that meeting was called so that there could be open debate on Bill 41. I, too, was at that meeting, and, in effect, what happened was members were told at the commencement of the meeting that it was no longer possible for amendments to be made to Bill 41. They were told that it was already past that process and if any amendments were passed at this particular meeting, that that would, in effect, derail the process even further and the regulations wouldn't be and the new bill would not be passed. That was obviously incorrect information, but, nevertheless, the members that were present voted on that, pursuant to that misinformation, and the motion that was referred to earlier was passed, in which, which, in effect, precluded any open debate.

I can tell you that my members that I initially were talking to were very disappointed with the results, but after I had the opportunity to consider it further, I thought that that was the best thing possible, because what that did show was the disfunction within pharmacy and it did show, in, in, in my view, that things needed to improve and things needed to be, to be fixed.

Dr. Gerrard then, ultimately, introduced some amendments, some of which were accepted, including the membership's right to vote. In 2008, the draft regulations were provided, and I should add that MIPA filed a court application in that instance challenging the, the vote and the regulations in part on the basis that there wasn't proper consultation with the members. We appeared before the Honourable Madam Justice Brenda Keyser, and she ultimately ruled that although there were some issues and some problems with the manner in which things proceeded, it was not enough to warrant court intervention. Although we did lose that, in effect, that court fight, I do believe that we were somewhat vindicated by the results of the vote. I think many members of the profession have expressed to you already the reasons why they voted it down, and that included the fact that many felt there was not proper consultation.

Things, in effect, quieted down for a period of time and there have been some questions from the honourable Mrs. Driedger asking if there's been some surprises to the timing of this bill. From my perspective, there wasn't really any surprise at the timing of the bill. I'd understood it was coming, but what was surprising was the council's recent decision to pass the motion indicating they did not support the members' right to vote as it currently appears in the bill before you. And why I did find that surprising was because of the fact that members repeatedly had voted over the course of the past seven years or eight years to keep their right to vote, and in spite of that, council still proceeded. Moreover, the motion of council was passed the day before the MPhA's annual general meeting which was held on April the 18th.

I was not present at that meeting, but for those that were in attendance, there was not one mention made of the motion that was passed by council at the AGM, and I know there were many of my members that have expressed to me that they felt that this was an opportunity for the council to advise the members that they had passed this, that they had passed this resolution where they were not supporting the vote, but for reasons known only to them, they chose not to do so. In fairness to the council, they did circulate a letter, approximately, I think, four or five days afterwards, but, again, many members expressed their disappointment that they weren't advised at the AGM so that they could have open debate and dialogue at that, at that particular time.

Madam Chairperson in the Chair

Many people have also referred to the fact that voting rights came in place in 1991, and what I found interesting is–I did–I wasn't personally aware of why voting rights came in place in, in, like what happened in 1991 to give them voting rights? And a review of the presentations back then were interesting. I should pause to note that I wasn't present there. That was, that was back in 1991 and I was figuring it out and I was enrolled in grade 11 in Mr., Mr. Whitehead's riding of–at Margaret Barbour Collegiate in The Pas, but I did have a colleague review the, the transcripts–

Madam Chairperson: You have 30 seconds remaining, sir.

Mr. Unfried: What it indicated is that the MPhA and the MSP were urging the government of the day to allow members to have the vote. They felt that they were losing the direction of pharmacy within Manitoba and they felt it was necessary for their members to have direct control over their pharmacy practice, and that included their ability to vote on the regulations.

What's changed since then? In my view, the only thing that has changed is the defeat of Bill 41. Pharmacists should not be punished for simply voting against the regulation. There were good reasons for its defeat and the MPhA–we should continue to work with them and with their members in the future to ensure that doesn't happen again.

Madam Chairperson: Thank you very much.

Ms. Oswald: Yes, thank you very much for your presentation tonight and offering, once again, an historical perspective of part of this journey. It's important as we go forward in our deliberations, so thank you for being here.

Mr. Unfried: Thank you.

Madam Chairperson: Thank you, sir.

We will start the process of calling people for a second time. Starting with Greg Skura of Super Thrifty Drugs Canada.

Is Mr. Skura present? Greg Skura. Not seeing him, his name will drop off the list.

Next, we'll call Mel Baxter. Welcome, Mr. Baxter. You can start whenever you're ready.

Mr. Mel Baxter (Private Citizen): All right. Thank you very much.

Good evening. You already know my name is Mel Baxter and I wish to make a presentation as a private citizen in support of Bill 18 as it's currently written. We have handouts, which are on their way. I could list off my background, but it's half a page and I think you can read it anyways, so for brevity, we'll move on.

When I looked at it, I'm saying to myself, well, that's pretty impressive but the reality is, is that I'm a practising pharmacist, a practising community pharmacist, and I deal in patient care everyday. Patient-centred care is now a byword–I'd be glad to define it if we want to go into that a little later, at least as I understand it–but we practise that everyday. I share the same passion that every one of you presenters–the pharmacist presenters that have been before you–hold. I'm very passionate about the profession. In fact, it's my honest opinion that Bill 40–or the regulations to Bill 41 did not go far enough. And it's in that venue that we want to continue to work with MPhA to, to improve them, to improve them, to take them forward.

I'm not going to read the whole, the whole presentation because some of it, others before me have, have indicated. I, too, was in Halifax, just like Elmer, and I, too, made an effort to get back here. I'm more tired than he is 'cause I left earlier. But, in any event, we were down there and took in some of those seminars as well.

When I listen to some of the speakers earlier mentioning thing, I just feel for–there's a few things I have to rebut and that is this business of numbers. How many numbers does it take to pass a bill, a motion, whatever? There was some discrepancy or disparaging aspect made about this Probe Research that we conducted that said there were 93 percent in favour of members maintaining their right to vote. Well, Probe Research is like Ipsos-Reid or whatever; I mean, are they not 2 percent accurate 19 times out 20? Something like that? So are we going to throw that out? I, I would hope not.

All right, moving on. I do not support any amendments to section 210, 211 which would remove pharmacists' right to vote directly on regulation changes to the regulations that govern the profession and the code of ethics.

I'd also like to, just briefly, from my point of view, get the issue of public safety off the table, in, in my eyes, because the issue of publi–on the issue of public safety, few if any pharmacists would object to regulations that improve the delivery of medications. I've, I talked to them all day long, in meetings or just in consultations, exchanging copies or whatever. Nobody's against improving the delivering of medication. And the reality is, government would ultimately have the final say in any re–any regulation affecting the public safety or public interest issue. Who better to help develop these regulations that those are on the front lines that deal with the, the patient every day?

***** (21:30)

The issue of pharmacy technicians. The Manitoba Society of Pharmacists' position is that

pharmacy technicians must be able to practise to the full extent of their knowledge and skill. I won't go into the whole business of pharmacy technicians except to echo Elmer Kuber's remarks that state, we all use pharmacy technicians, whether they're licensed under the current educational process or have been trained internally. There will be strengthening pharmacy technician programs that will bridge those that are functioning as assistants or whatever right now to get them up to speed as a licensed pharmacy technician, as well as expanding schools across Canada to turn out more pharmacy technicians. We want them to take over the physical act of dispensing. We're not th–no different than hospitals in the community in that regard. We want to be free to spend more time with a patient. In fact, I'd like to be standing up here in front of Manitoba Health, stating why I think we should have a better reimbursement process for patient-centred care. So that's an issue for, for later on in another day. But, just to reiterate, we are not in any way objecting to pharmacy technicians fulfilling their full role in the health-care provision for providing of medication.

Oh, as I say, I'm not going to reiterate everything 'cause it's there for you; you can read it. But I'd like to go on to the issue of pharmacists' right to vote on their regulations. This was debated and passed on Bill 41. Without the right to vote we would have regulations in place that were supported by 34 percent of the pharmacists. To me this is not acceptable. It's just flat out not acceptable, and people can argue about the fact that maybe a majority didn't bother to place a ballot. That, my goodness, we–in this day and age, with mail, with e-mail, and I'm sure at some point in time we'll even have video voting, I'm sure we can find a way to get more participation for those that want to.

The profession of pharmacy is unique. It is the only health-care profession that the public has direct access to for advice and direction. Pharmacists work in both public funded institutions and overtly commercial environments. The profession is undergoing significant changes as the focus of health care shifts to wellness and prevention, patient education and outcome management. Pharmacists are essential to lower health-care costs and improve patient lives. We need and deserve the right to develop and improve regulations that support that end. I mention there about the survey, which we've already talked about, and I won't, I won't repeat that. But better that pharmacists work together and approve regulations that then get sent on to government for their careful consideration, and, hopefully, approval, than do it the other way around, which has a regulatory body send you the regulations, and that we lobby like heck to change 'em because we don't like 'em. I think we can work together. I think that's accentuated by the fact that we have a system in place where PricewaterhouseCoopers is meeting with MSP and MPhA to find some common ground on these, on these regulations. I'm confident that that will be successful. I'm confident we're not that far apart and that we can reach agreement here.

I would like to speak for a moment about the reason for the delay, because that seems to be an issue. Why has it taken–they were passed 18 months ago, our Bill 41–why has it taken so long for these regulations, once defeated, to be tinkered with, modified a bit and put back out to the membership for a vote? And, I would like this committee to know, that in no way has MSP stood, Manitoba Society of Pharmacists, stood in the way of that process. In fact, we've actively lobbied MPhA to get the work done. Let's get it done.

We were institu–or instrumental in getting the subcommittee report set up back in July, which reported back to MPhA at the end of September, and that took 'em til April 17th of this year, '09, to move motions on those subcommittee reports after we constantly asked them for where did they stand, what were the results of the subcommittee reports? What was their opinion? They would never give us an answer. So, as I say, I 'd just like to dispel that possible rumour that M–MSP, Manitoba Society of Pharmacists, has in some way held up, held up this process.

As I say, why NPhA–or MPhA would not have taken just a little more time and improved the likelihood of a successful vote on the regulations has never really been understood, because they were in complete control to determine the time required to get the necessary support to get the regulations passed.

To dispel another rumour, you hear, no doubt, from MPhA that they took a comprehensive consultation process, and, to this very day, I've heard it said that they indicate they did a phenomenal job, but the results speak for themselves. The phenomenal job–it was suggested that this process has been in the works for seven–I believe the, the mention was seven years. Well, as an independent pharmacist out there, I can only remember one

meeting a year at which there wasn't much said, and it was basically indicated, well, this possibly may be where we were going. We never discussed or ever looked at the whole draft. There really was never any formative consultation in that process. There was just regional meetings, one a year–

Madam Chairperson: You have 30 seconds remaining, sir.

Mr. Baxter: –okay, thank you–which attempted to bring us up to snuff, and it just was not adequate.

Okay, just to finish off, then. I would just like to indicate that community pharmacists, pharmacists in general, want to see the profession advance. We want to see the advent of the patient-centre care developed. We want to see the use of pharmacy technicians. We want to see the advent of prescriptive authority, perhaps the development of a minor ailments list that would extend the scope of what we do right now when we counsel on over-the-counter products, so we're in no way a hindrance to this profession moving forward.

Madam Chairperson: Thank you very much, sir. Thank you.

Ms. Oswald: Yes, thank you. I will echo the words of Madam Chair: thank you very much for contributing to the discourse this evening. Thanks for being here.

Mr. Gerrard: I'm impressed by the thoroughness of the comments in the package that you've provided us, which provide detailed views on a whole lot of the regulations.

Maybe you can give me impression on two things: one is, you know, how close are things? Are we close to a resolution of the situation on the regulations, or, and the second one, you've talked about–about your vision for, in fact, going farther in some areas.

I just want to give you an opportunity to expand on that a little bit and tell us where you see that.

Mr. Baxter: Thank you. In terms of the PricewaterhouseCoopers report and the ability to get the regulations passed, personally, I am confident that with both parties demonstrating goodwill and without–and with having an assistance from the consultant, that none of these issues are insurmountable. In fact, that is our raison d'etre. We want these regulations to go forward, such that the Manitoba Society of Pharmacists can endorse them. Then we can get a majority vote, if not a unanimous vote. Okay.

The other question about the future–well, like Elmer, I was in Halifax and there were a lot of seminars and discussions and whatever, but this idea of patient-centred care where pharmacists start to speak the language that physicians use, so we're on a common ground here. We want to be able, we want to do, we do it already, patient histories just as a physician would do, although we're not, we're not delving into their realm. We're not trying to diagnose or whatever, but we want to get an idea of their blood pressure. Do they have blood sugar levels? Do we need to know INR results for blood clotting? Dietary restrictions, drugs that they're currently on, age, weight, all these things that would be important to making the right, right decisions in terms of moving on to the next aspect, which is patient care.

***** (21:40)

So, working in collaboration with other health-care providers to suggest a drug-therapy regime that would be adaptable to the individual, to the patient, that would be specific for them, developed specifically for them. And then, of course, we want to evaluate the outcome and follow-up with, with the physician and/or the nurse and/or the dentist, even, in some cases, in my own practice. Follow up with the outcome and such that there can be modification. In order words, full patient care. Hope that answers it for you.

Mrs. Driedger: Thank you, Mr. Baxter. You may have already answered this, but I'll–you know, if you want to say anything more about it. My question was going to be: what is it going to take for this fractured profession to heal?

Mr. Baxter: Approval of the Bill 41 regulations and maintaining the membership's right to vote.

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

Next, I'd like to call Barbara Sproll. You may begin whenever you're ready, Ms. Sproll.

Ms. Barbara Sproll (Private Citizen): Hello, I, I'd just like to thank everybody for this opportunity to speak.

Just to give you a brief background, I've been a pharmacist for more years than I really like to admit–

especially on public record–but, we're planning our 30th reunion, so that kind of gives you an idea of how long I've been doing this. But admittedly, over half of that time has been out of this province and another half of that time has been out of this country. I most recently just returned back to Manitoba from being overseas in the Middle East last May. So I've come into this mess, as everybody's describing it, and sort of not really knowing how did we get here. I left Canada in January of 2005 and there were issues and everything, but now I've come back and–I don't know, they certainly haven't gotten any closer to being resolved.

I am currently an employee of the Winnipeg health region. I am a medication–or the medication safety pharmacist for the region. I am also the current president for CSHP Manitoba branch, but today I speak to you as a private citizen. Kyle MacNair spoke yesterday on behalf of CSHP and, certainly, I concur with everything and, and helped him develop the, the position statement that was proposed yesterday on behalf of CSHP.

I just–I don't want to start rehashing all the reasons why we don't support Bill 18 the way that it's written. We've gone on record, many of us, stating that we think that the membership vote is not the way to go. It's an umbrella act. I support the idea of consistency; I support the idea of transparency.

But having listened for the last two days–and I was actually at meetings yesterday morning as well–what's hitting me–because I've always been a hospital pharmacist, I could probably count the number the days I've spent working in a store–is that this is a very complex practice that pharmacy is involved with because we do have the two aspects and this is what's making us look like we're so divided. I don't think we really are and I mean, certainly, based on the, the presentations by community, by the academia, by the hospital people, we all care about patient safety. I don't think this should become a debate of who cares more–because then I do, because I'm a medication safety pharmacist–but that's not the issue. We care about our patients and every pharmacist I've ever met cares deeply about their patient, but there is that commercial aspect. I don't have anything to do with it; I've always worked in a hospital. I have the luxury of devoting all of my time to medication safety, to promoting patient safety. I realize that's a luxury and I'm very thankful for it and I, you know, take it very seriously. But that doesn't mean I'm not sensitive to the commercial aspect of the pharmacy practice, and we need a way to put the two aspects together and somehow come up with a new set of regulations.

As a medication safety pharmacist, of course, I promote the better use and safer use of medication. Research shows the pharmacist being involved directly with the patient medications–from the selecting, monitoring, follow-up, making sure that they're taking them properly–that is the best use of pharmacists' time. There are numerous articles in, you know, various medical journals–of course, mostly pharmacy journals–that show patient safety is increased by having the pharmacist accessible to the patient, to the physicians, to the nurses, when the medications are being prescribed, when decisions about care are being made, and then having the pharmacist follow up. That–you know, if you want the references, I can pull them for you.

Same with the technicians: Time and time again, there are articles showing up that technicians are actually better at dispensing, doing the actual checking of the dose. And, you know, there's different theories about why that is, but one of them is because that's all they're worried about. They're not thinking, oh, I wonder what their renal function is and I wonder, you know, should I be doing this. They just are going, this is the drug, this is the drug, this is what the paper says, they match, and bang on. So, again, regulating the technicians, training them, certifying them, recertifying them annually; that is the way to go for accurate, good, safe patient dispensing.

So what we need to somehow put these ideas together, keeping the commercial aspects in mind. We need to get to that point that we all, I think, in this room, agree we need to be at. Nobody is debating what pharmacy should be doing, and, you know, the technician role needs to evolve, but I think everybody realizes we need to go in that direction.

Again, I want to stress that, ultimately, I support the health profession act in its original premise: consistency, with council having the voting privileges or the, the right to pass regulations. I don't think it's in the best interests of the pharmacy profession or the patients to have it always go back to the members because we are a big group with a lot of different concerns. So this is why we have these delays, because everybody's bringing their own individual perspective to the table.

In the last couple of days, the idea of splitting up–and that's the paper that I, I presented–splitting up some of the–and I hate to divide it like this because I don't want this split in pharmacy–but the professional aspects versus the commercial aspects. What I'm talking about are the, the aspects that govern a store and a commercial part of the practice, and then the part of the practice that is me, as a pharmacist; what do I need to do? Separate, whether I'm working in a store or a hospital, in that the college, whatever I'm doing, as a pharmacist, there needs to be regulations. As a store and a commercial enterprise, there need to be regulations. I can't comment even on what a store needs. Like, I mean, inducements and advertising and stuff like that, I don't feel that that's my place, and I'd like to go on record that the hospital pharmacy has never have an issue with the idea of inducements for stores.

Anyway, so, I just sort of propose that maybe this is an option. As the honourable minister has stated, this is a marathon. I think we ultimately need to get to the point where with the health professional act where we're all doing the same thing regardless of the health profession. But, again, with Bill 41 still on the table and we need the regulations, maybe doing it in baby steps like that to reach the final–whatever a marathon is, 'cause I've never run one, 26 miles–that this might be the way to go. And that's all I have to say.

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

Ms. Oswald: Thank you, Ms. Sproll, for presenting a very important side to this argument. I also thank you for what I think is a really valuable piece of paper, valuable information on it. Thank you.

Madam Chairperson: Are any other questions? Seeing no other questions, thank you for your presentation tonight.

Next, we'll call on Pat Trozzo. Welcome, Mr. Trozzo. You can begin whenever you're ready.

Mr. Pat Trozzo (Private Citizen): Madam Chair, Honourable Minister Oswald, members of the committee, thank you very much.

These comments represent the personal views of Mr. Shawn Bugden and myself, Mr. Pat Trozzo. Mr. Bugden has practised as a pharmacist in both retail and hospital environments. He is currently the regional director of pharmacy for the Central Regional Health Authority, the vice-president of the Manitoba Pharmaceutical Association, and an assistant professor at the Faculty of Pharmacy. As well, he is a member of the Manitoba Society of Pharmacists and the Canadian Society of Hospital Pharmacists. I am currently the site manager for the pharmacy program at CancerCare Manitoba, a clinical assistant professor at the Faculty of Pharmacy. As well, I hold membership with–in the Canadian Society of Hospital Pharmacists, the Canadian Pharmacists Association, as well as the Canadian Association of Pharmacy in Oncology. Our comments are being provided as private citizens.

***** (21:50)

The Regulated Health Professions Act represents an important and commendable step forward to enhance the consistency in the governance of health professions. The government should also be commended for mandating a one-third complement of public representation on the council.

It is unfortunate and inconsistent that an exception for pharmacy effectively undoes these, these intentions of the legislation for the profession. The requirement for all pharmacists to approve regulations, standards of practice, continuing competence and code of ethics treats pharmacy differently from all other health professions in Manitoba. This change effectively places council members of the Manitoba Pharmaceutical Association in an extremely difficult position of taking an oath of responsibility to protect the public, but places the final decision making in the hands of all pharmacists. It is only pharmacy that has been placed in this unenviable position. By including this exception, the government has disregarded its own goal to achieve consistency in health professions' regulations and enhanced role of the public.

In correspondence from the Ministry of Health and Healthy Living, the government justified this is–inconsistency by suggesting that the business component of pharmacy makes it unique. It seems surprising in legislation that governs health professions to protect the public that business concerns would predominate. Clearly, other professions also have business concerns. Furthermore, pharmacy in other provinces would also share business concerns, but they have not found it necessary to create an exception for the profession of pharmacy. This includes British Columbia, on which legislation Bill 18 was modelled.

A valid process is required for good decisions to be made; if the process is flawed, there exists a greater opportunity for poor decisions. What if this

committee had to defer its decision until it had a vote in the constituency of each MLA? That may make for a decision that would be supported by the majority of the constituents, but would it be the best decision, and would it be made in a timely manner?

Allowing council to do the research and consultation with the members, stakeholder groups, and then forward the decision that is consistent with the mandate of the college is the method that has been applied to other health professions and should be the process that pharmacy follows. The current council of the Manitoba Pharmaceutical Association has repre–representation from government, the Canadian Society of Hospital Pharmacists, the Manitoba Society of Pharmacists, the Faculty of Pharmacy, public representatives, as well as practitioners from hospital practice, community practice, long-term care, as well as the International Prescription Services pharmacy, or IPS. Seventy-five percent of our current elected councillors practice in community pharmacy, and our president is a community pharmacist working in the IPS industry. As you can see, the council has diverse representation from all practice areas of pharmacy and thus can be representative of the membership.

There's been a great deal of discussion these last two evenings about the divisiveness within the profession and why this exists. There have been inquiries as to what measures could have been taken sooner to have avoided the distrust. We believe that much of the–this acrimony has been secondary to the member's current right to vote on the regulations.

Once Bill 41, The Pharmaceutical Act, received royal assent on December 4th, 2006, the council of Manitoba Pharmaceutical Association began the process of regulation development. A draft discussion document was sent to the pharmacist members in April 2007 for input. Response was received back from 20 percent of the membership, with o–overwhelming support of the document. Comments received were considered by the council and changes incorporated into a second discussion document. Based on the comments and input received from the members and stakeholders, a policy document was released to the members for approval in December of 2007. As the committee has heard, the document did not receive membership approval. Some have said that this is because council had not listened to what the members wanted.

The Manitoba Pharmaceutical Association has invested over $100,000 to develop the regulations policy document pursuant to the December 2006 pharmaceutical act. As we have said, many changes along the way, secondary to the feedback received by the members, was implemented. Before the members were asked to vote, over 95 percent of the document had received over 90 percent of the appro–approval rate.

So what happened? Well, we submit that the members were bombarded with a vote no campaign by one of the advocacy bodies and one of the trade org–organizations. Members were encouraged to vote no secondary to some misinformation and scare tactics. The advocacy body is on record that the no campaign was there to protect the economic interests of the pharmacist members.

You will hear from the Manitoba Society of Pharmacists, the largest adv–advocacy body in the province, that they support pharmacist voting under Bill 18. This is an entirely predictable and reasonable position for the advocacy body to take. The advocacy bodies of other professions may also want a vote, but this has not been proposed. It is only the profession of pharmacy that has the difficult task of convincing its members they should give up the right to vote, contrary to the well-organized campaign of the MSP. All professions have a balance between their advocacy body and the regulatory body. Pharmacy has the same balance and should have the same consistence–consistent governance structure as other professions. A number of checks and balances exist to ensure that all viewpoints are considered, all regulatory bodies are required to extensively consult with the members as they perform their functions. Pharmacy's regulatory body would be required to engage in the same thorough consultation. Currently, pharmacists may require the regulatory bodies hold a special general meeting when approximately 65 pharmacists petition the need for such a meeting.

Lastly, the government has the final word on regulations and can exert this power to make adjustments should the regulatory body have been overzealous in its public protection role. Under Bill 18 as written, the government will receive every regulation, competency program, or standard of practice that pharmacists pass by simple majority at a general meeting. Would not the system and the scarce resources be better served if the pharmacy council did the research, consultations, weighed the interests of the public, and worked to achieve consensus and then forwarded the approval on to the government rather than a simple majority of the

members collected at a general meeting? This would be the process with all other health professions in the province and seems to make clear sense for pharmacy as well.

In the correspondence from the Ministry of Health and Healthy Living, dated May 7, 2009, quoted earlier in this presentation, the ministry points to a recent publication of the *Canadian Pharmacists Journal* that suggests the uniqueness of pharmacy. I quote: Among health professions, pharmacy is unique as the large majority of community pharmacists practice within an overtly commercial environment. End of quote.

As the article points out, it is this uniqueness that causes important conflicts. The authors state that within a community pharmacy there has been a long contradiction between the professional mandate of practice and the reality that the profession practises in a commercial environment. It is exactly this conflict that makes a governance structure that protects the integrity of professional practice essential. The article concludes that the dual role of pharmacists as professionals and business people can be detrimental to the professional role and the overall image of pharmacy.

The government has a responsibility to ensure consistency in the regulation of all health-care professions and to protect the public against commercial self-interest. The uniqueness of pharmacy makes it–this more important for pharmacy, not less.

There have been those who presented before this committee indicating that Bill 41 was amended at the last minute to reflect the importance of voting rights for the pharmacist members and why should that be different in Bill 18. The Regulated Health Professions Act is different from Bill 41, The Pharmaceutical Act, because of the clear mandate and detailed description of protection of the public of the college and the council members and the oath that they must take. That is what has changed since the unanimous support of Bill 41 in the Legislature, and we do not believe that they can be compared. The Manitoba Pharmaceutical Association is committed to the PricewaterhouseCooper process that has been initiated for regulation development and this will continue irrespective of what the final version of the regulated health profession act is. Once a set of regulations has been developed and approved by the members for Bill 41, this could then be brought under the health, Regulated Health Professions Act. These are two different issues, and one does not necessarily determine the other.

In closing, it is the uniqueness of pharmacy that enhances the importance of a balance of business interests with professional practice standards and public protection. It is the role of the Manitoba Pharmaceutical Association to ensure professional standards that ensure safe medication practices for the public. It is the role of the Manitoba Society of Pharmacists to represent the interests of pharmacists including their business interests. Our government has the responsibility to ensure this balance and protect the public interest. The responsibility is met by having the profession of pharmacy governed in the same consistent manner as with other health professions, and we are asking for consistency of governance with the public interest placed above that of the pharmacist, which is what any government would and should want. Thank you.

Madam Chairperson: Thank you very much.

Ms. Oswald: Thank you, Mr. Trozzo, for your presentation. It certainly does outline in very strong terms points of view from the Manitoba Pharmaceutical Association and many pharmacists we've heard from tonight and last night. Thank you for being here.

***** (22:00)

Madam Chairperson: Thank you very much, sir.

Next I will call Michelle Glass. Michelle Glass? Michelle Glass here?

Not seeing her, she will drop off the list.

Next I'll call Jeff Uhl.

Welcome, Mr. Uhl. You can start whenever you are ready.

Mr. Jeff Uhl (Private Citizen): Thank you. I just want to say thanks for everybody taking the time to listen to all of us.

My name is Jeff Uhl. I'm a small town, rural Manitoba farm boy. I graduated from pharmacy faculty here in Manitoba in 1992, and I've been a business owner for a few years. And I am currently in the IPS industry.

I'm going to be very brief. I think it's important at this point in time that we, as pharmacists, retain our right to vote on our regulations. I feel that if it was a perfect world, there really would be no reason

for us to have to have this vote but right now, there's so much division in pharmacy, it's not a perfect world. I'm going to be blunt and say that I don't think the MPhA council can be trusted at this point with the power that they've been given on these issues.

I think that IPS is a perfect example even though time and again it's been shown to be a progressive industry, very safe industry, council has done everything they can in the past few years to try and remove the industry from Manitoba. Now, you know, IPS is just an example. If I thought that this was just an IPS issue, well, I probably would have just moved to B.C., you know, two or three years ago instead of, you know, staying and fighting over all these issues. But I guess the question for me–the reason, you know, why did I stay? Well, I stay because I want to stay in Manitoba, and I think it's important that, you know, pharmacists have their voices heard. I think the PWC process is very important because I think it might, you know, help to shed some light on the problems that are happening within the MPhA council.

That's all I have.

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

Ms. Oswald: It has been proposed by me, in fact, and others that an ultimate goal for the profession of pharmacy would be to get to a point where voters, maintaining voters' rights for the membership voting on an issue is kind of a moot point, because the profession would function as many of the other professions do, professions that are advocating, in fact, for pharmacy to be treated the same as they are–nurses, doctors and the like.

What would you think about that notion, that the ultimate goal would be to have the voting rights not even really matter and that the profession functioned through a council, through a college, the way that other professions do?

Mr. Uhl: Thank you. Like I said before, in a perfect world, I mean, that would be ideal, but I just don't see–like, there seems to be so much conflict of interest within the MPhA council. I mean decisions are being made by six or seven people in a room which, you know, affect, you know, affect, you know, people like me that would force me to take my profession to another province. And I just don't think that–I really don't feel that at this time anyway that, you know–I'm not sure how to word it. I'm sorry.

I just really don't feel that decisions are made with the public interest in mind. Like they can say that, well, we make this decision because it's in the best interests of the public, but I think that, you know, people hide behind that statement a lot.

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

Mr. Uhl: Thank you.

Madam Chairperson: The next name I have on my list to call a second time is Blake Taylor.

Welcome, Professor Taylor. Do you have a written presentation?

Mr. Blake Taylor (Private Citizen): Yes, they're handing it out. It's good to see a number of people here who have worked hard over the years for the people of Manitoba in the field of health care.

The Regulated Health Professions Act, a public perspective. I applaud some of the elements of this bill, particularly the addition of an ongoing role for the minister in the functioning of the colleges and the consequent addition of some opportunity for the public to appeal to the minister about college functions. I know that in the case of the current minister, this latter has meaning because she is one who listens to ordinary citizens. Nevertheless, considering that, quote, "the overriding duty of all of the colleges is to serve and protect the public," end of quote, it is my view that, disappointingly, the rights of the public, the role of the public and the importance of the public do not appear to be sufficiently well represented in the proposed legislation as it currently stands.

The colleges are granted by government authority and, in fact, monopoly over reserved medical services. Since this is the case, I propose that corresponding responsibility be put in place in the new legislation. Making this responsibility explicit in the legislation is essential for reasons of accountability, of guidance and of public confidence. And to whom are the colleges responsible? To the public, to the patients and families of Manitoba that these colleges serve and, secondarily, to the government that grants these colleges their authority. Responsibility to the members of the college should not be primary because, in such circumstances, the public and the patients and families in Manitoba are at risk.

I love our public health-care system in Canada, and the vast majority of workers are dedicated,

competent and commendable, but unless we make some serious re-assessments of our college system, we're in trouble. The consultation document received, we received a few months ago, states under objectives of reform, continue to place the interests of patients and the public at the centre of the regulatory process and foster greater confidence in the provincial health-care delivery system.

In order to build confidence in all colleges under the new legislation, it is paramount that they are perceived to be fair, transparent, and responsive to the needs of the public that they serve. It must also be apparent in practice that it is the public that the colleges serve and, indeed, the interests of patients and the public be at the centre of the regulatory process.

The following suggestions are intended to strengthen the achievement of the above stated goals. Specific suggestions: Currently, under Manitoba, under the mandate part 3(10)2 in the legislation, there are 10 points. The only place the public is mentioned is under (h) as follows: to promote and enhance the college's relations with its members, other colleagues, key stakeholders and the public.

Well, I submit the public is, or should be, the primary stakeholder. There are a million of us and we all rely on the colleges. I propose that two additional points be added under mandate and that they be placed at the top of the list where I think they belong: (a) To govern its affairs first and foremost in the interests of the public at large and to conduct all of its business as a representative of the patients and families of Manitoba; (b) to acknowledge the patients and families of Manitoba as the primary stakeholders in Manitoba's health-care system and to set up patient and family advisory councils constituted primarily of lay people mandated to advise the college on their activities and to report to the minister.

This is not unheard of. I have attached from memory a rough facsimile of the terms of reference for MPAC, the patient advisory council of the Manitoba Institute of Patient Safety, as a model for this kind of mandate and the activities of such advisory councils. I'm sure you can get a copy of the original.

I'll use my experiences and knowledge of the College of Physicians and Surgeons of Manitoba as the basis for the following recommendations:

Complaint statistics. The legislation should include as requirements the following: the number of complaints from members of the public should be published, counted, categorized as to type of complaint, level of investigation reached and final disposition in a proposed annual report available to the public. This report should be required to be published within six months of the year-end.

Complaint process. I note from the publicly published minutes of the MIPS board, June 2008, that in reference to this proposed act, quote: two sections: actions and complaints and discipline–disciplines processes were written–are written, and feedback requested from the 22 regulatory bodies–end of quote.

***** (22:10)

Well, I'm here to give voice not to those well-represented 22 bodies, their administrators, lawyers and members, but to the patients' and families' perspective, which, I hope, will be taken with the seriousness that it deserves. I speak from personal experience, and in my heart I think of the many citizens, families with whom I have spoken, who believe that the prolait–complaints process of the College of Physicians and Surgeons is deeply flawed and unsatisfactory and in no way represents a fair, equitable, evidence-based, unbiased model. And I have to say this view is held by most of my students at the university. I welcome the college to take a survey of that perception at universities in Manitoba.

In particular need of reform is the complaint process, where, in the interests of fairness and perceived fairness to a complainant, the following changes should be put in place as requirements in the new legislation: The same individuals who made up the complaints committee should not be appointed to the investigations committee on the same matter. An opportunity should be provided for a complainant, should the complainant wish it, to meet in person with the investigation committee and its investigator in order to verify that important aspects and/or details of a complaint are understood and included and that the related documented evidence is accounted for.

Another one is a complainant should have the right to appeal to an external body out-of-province after the college has made a final decision about a complaint, this body to be instructed to be fair and impartial and to weigh evidence provided. The duty to address documented evidence thoroughly, specifically, impartially, and in a way that the

college believes will withstand scrutiny should be stated in the legislation. Rationale for this? The health profession's regulatory reform consultation document states, quote: Principals of fairness and due process across all professions. The effectiveness of the complaints and disciplines process will be improved for those professions who are currently regulated under the old statutes. Well I hope that includes physicians and surgeons.

When a complainant is representing a vulnerable loved one, which is often the case, I expect, I believe that the evidence that the family provided, and–no– and if the family believe that the evidence they provided was not addressed in a credible way, then the complainant should have a clear right to meet with those at the college who made the decision in order to come to a common understanding. Without this revision, the college will never achieve the confidence of the public.

Those working within our health-care system need to understand that while the health-care professionals, most of whom are doing a fine job, need to have the right to represent their case in person in order to defend their professional dignity or reputation, the complainant has just as much at stake in representing a vulnerable loved one that they believe has been harmed.

For the benefit of all parties, it should be a responsibility of the college to provide answers that address evidence and withstand scrutiny.

I think I'm running out of time so I'll jump to restrictions on complaints. The new legislation should require the colleges to accept the executor's written authorization of a delegate and then to deal directly with the delegated party as if they were the executor. And under mandatory reporting of critical incidents, I'd like to add into the legislation a clear and strong clause requiring health-care professionals to report what appear to them to be critical incidents.

If I'm not out of time I'll carry on.

Madam Chairperson: About 30 seconds remaining.

Mr. Taylor Regarding the last point about stating the duty to address evidence in a way that the college believes will withstand scrutiny, this provision is to make it clear to the public that complaints matter– that in complaints matters, the colleges are not just looking out for the rights and interests of their own members, but are equally concerned with the fairness to the complainant. In a complaint situation, the colleges should be modelled after the judiciary in terms of impartiality and thoroughness. This type of provision would also help answer the view, which in my experience is widely held by members of the public, that self-regulation of health-care professions doesn't work.

Am I out now?

Madam Chairperson: This concludes your time. Thank you very much.

Ms. Oswald: Yes, thank you, Professor Taylor. It's nice seeing you again. We–if I'm not mistaken, I think you're the last presenter that we'll hear from. I can't really think of a more appropriate voice to end this dialogue reminding us in all of our wrangling why we're here, and I appreciate tonight and many days that we have a chance to speak, the role that you play in promoting safety of patients and the voice of the family in ensuring that we have the best health-care system that we can. So thank you for being here tonight, and these are important words.

Mr. Gerrard: Thank you, and well thought through comments, obviously from a lot of experience dealing with medical errors and concerns.

One of the things which I'd ask you to comment on is the fact that we've got a medical error reporting process, but we've also got a complaints process going to the college, and in some ways they complement one another because of the nature of the college's investigation, for example, with medical issues. But it's important that the information which comes from the two processes comes back together in terms of the final recommendation as to how we address medical errors, and I'd like you to just comment on that.

Mr. Taylor: I think you're right that they are potentially complementary. And I think that we all recognize the importance of Bill 17 in the reporting of medical errors and the fact that they're not being reported; that most of them are not being reported. And that that's a huge problem because we can't start changing or improving systems or individual training or whatever it is until people start reporting. And that's a new thing and it's coming slowly. And the college plays a role and so do the health authorities and everyone, really, in the system.

And it's–I don't know the answer to that, Dr. Gerrard. You know, you and others may have a

lot better thoughts on that than I have, but I think that there is a place to co-ordinate that and I think it certainly begins with not just saying we put patients at the centre, but making that a reality, holding senior administrators and those under them, and all the way down the line from top to bottom, responsible to see that things like Bill 17, the reporting of medical errors, that The Apology Act, that the new fee amendment act that's coming in–that all of those thing–well-intentioned pieces of legislation, come to fruition, that are made in order to improve the system aren't dissipated in a way that they really make no change.

I don't know if that's an answer, but–

Mr. Gerrard: Thank you.

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

That concludes the list of presenters I have before me.

Are there any other persons in attendance who wish to make a presentation? Seeing none, that concludes public presentations.

In what order does the committee wish to proceed with clause-by-clause consideration of these bills?

Mr. Chomiak: I was considering staff in public–we've heard from the public. We have the staff from Justice for Bill 11, 13, 15, and 18. Perhaps we should do the Justice ones first and then the medical ones later, which would–I'm just throwing that out as a proposition. I think there's a–there's no presenters to the two Justice acts, so perhaps we should just plough through those two and let the Justice people depart and then continue on.

Madam Chairperson: Is that agreed? Okay. We will proceed through the two Justice acts and then through the two Health acts.

During the consideration of a bill, the table of contents, the enacting clauses, and the titles are postponed until all other clauses have been considered in their proper order. Also, if there's agreement from the committee for the longer bills, I will call clauses in blocks that conform to pages with the understanding that we'll stop at any particular clause or clauses where members may have comments, questions, or amendments to propose.

Is that agreed?

An Honourable Member: Agreed.

Madam Chairperson: That's agreed.

We'll now proceed to clause-by-clause consideration of the bills.

***** (22:20)

Bill 15–The Victims' Bill of Rights Amendment Act

Madam Chairperson: We're going to start with Bill 15, which is The Victims' Bill of Rights Amendment Act, because I understand that staff for the other bill are on their way here.

Does the minister responsible for Bill 15 have an opening statement?

Hon. Dave Chomiak (Minister of Justice and Attorney General): No, Madam Chair.

Madam Chairperson: We thank the minister.

Does the critic from the official opposition have an opening statement? I see none. We thank the official opposition. We'll move to clause-by-clause consideration.

Shall clause 1 and 2 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 1 and 2 are accordingly passed.

Shall clauses 3 and 4 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 3 and 4 are accordingly passed.

Shall the enacting clause pass?

Some Honourable Members: Pass.

Madam Chairperson: The enacting clause is accordingly passed.

Shall the title pass?

Some Honourable Members: Pass.

Madam Chairperson: The title is accordingly passed.

Shall the bill be reported?

Some Honourable Members: Agreed.

Madam Chairperson: Agreed. The bill shall be reported.

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

Madam Chairperson: We're going to move on to Bill 11, The Highway Traffic Amendment and Manitoba Public Insurance Corporation Amendment Act.

Does the minister responsible for Bill 11 have an opening statement?

Hon. Dave Chomiak (Minister of Justice and Attorney General): Yes, thank you, Madam Chairperson. There are–we're going to proceed with two amendments to the bill. We–I talked with the opposition critic about four amendments, but wanting to follow the rule that we generally follow, two of the four amendments we had proposed are out of scope. So we're going to stay with–I have to stay within my own rules on this one. Much as I regret it, but one has to be consistent, so we only have two amendments.

Madam Chairperson: We thank the minister.

Does the critic from the official opposition have an opening statement?

Mr. Cliff Cullen (Turtle Mountain): Well, not as the critic, but certainly on behalf of the critic, the Member for Steinbach (Mr. Goertzen), I do want to thank the minister for bringing forward this legislation. And I do want to take this opportunity to thank all the Legislative Counsel staff that are with us tonight, on a long evening here at the Legislative Building, for the long hours tonight and, I'm sure, for the long hours they're going to have for the rest of the week. So I just wanted to acknowledge them tonight.

Madam Chairperson: Thank you very much.

Shall clause 1 and 2 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 1 and 2 are accordingly passed.

Shall clause 3 pass?

The honourable Minister of Justice.

Mr. Chomiak: Yes, thank you, Madam Chairperson. I move that the following be added after clause 3(b)(iii) of the bill: (iv) in clause (a.2) by striking out subclause (a)(vii) or (viii) and substituting any of subclasses (a)(vii) to (viii.2).

Madam Chairperson: Thank you, to the honourable minister. I believe in your statement you said subclasses; I think you meant to say subclauses. Just to be clear.

Mr. Chomiak: Yes.

Madam Chairperson: It has been moved by the honourable Minister of Justice that the following be added after clause 3(b)–dispense, any time?

An Honourable Member: Dispense.

Madam Chairperson: Dispense? Great.

The amendment is in order. The floor is open for questions.

Mr. Chomiak: The purpose of the proposed amendment to clause 3 will ensure the Manitoba driver who is convicted of impaired driving in the U.S.–it is similar, to any of the new Criminal Code impaired driving offences created under the federal Bill C-2–will have those convictions recognized with the purpose of suspending the driver from driving in Manitoba.

Madam Chairperson: Thank you.

Are there any other questions or comments on this amendment?

Is the committee ready for the question?

Some Honourable Members: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 3 as amended pass?

Some Honourable Members: Pass.

Madam Chairperson: Clause 3 as amended is accordingly passed.

Shall clauses 4 through 6 pass?

The honourable Minister of Justice.

Mr. Chomiak: Thank you, Madam Chairperson. I move that clause 4 of the bill be replaced with the following: clause 4, sub 1, subsection 279.1(1.1) is amended (a) by striking out 253(a) or (b) and substituting 253(1), sub a or sub b; and (b) by

striking out or subsection 254, sub 5 or 255, sub 2 or sub 3 and substituting subsection 254, sub 5 or any of subsections 255, sub 2 to 3.2

In addition, clause 4.2 will say, subsection 279.1, sub (1.2) is amended, (a) by replacing clause a with the following: sub a, a conviction for any offence referred to in any of the following provisions of the definition category B offence in subsection 264, sub 1(i), subclauses (a)(vii) to (viii.2) or (ii), clauses sub a.1 to sub a.3; and, (b) replacing subclause b, sub i, with the following: (i) an offence referred to in subclause (a)(iii)(iv) or (v) or clause sub a.1 of the definition category A offence in subsection 264, sub 1, and sub i, 1, an offence referred to in any of the following provisions of the definition category B offence in that subsection: (a), subclauses sub a (vii) to (viii.2), or B, clauses (a.1) to (a.3), or.

Thank you Madam Chairperson.

Madam Chairperson: Just, just for the record there are a few additions in the written version that we will have to make sure are not part of the record. I think you added in addition after (4), (1), (b), and and after (4), (2), double (ii) and another "and" after–right before sub b.

So we'll just remove those. It will be as written. Is that agreed?

Some Honourable Members: Agreed.

THAT Clause 4 of the Bill be replaced with the following:

4(1)Subsection 279.1(1.1) is amended

(a) by striking out "253(a) or (b)" and substituting "253(1)(a) or (b)"; and

(b) by striking out "or subsection 254(5) or 255(2) or (3)" and substituting ", subsection 254(5) or any of subsections 255(2) to (3.2)".

4(2)Subsection 279.1(1.2) is amended

(a) by replacing clause (a) with the following:

(a) a conviction for an offence referred to in any of the following provisions of the definition "Category B offence" in subsection 264(1):

(i) subclauses (a)(vii) to (viii.2), or

(ii) clauses (a.1) to (a.3);

(b) by replacing subclause (b)(i) with the following:

(i) an offence referred to in subclause (a)(iii), (iv) or (v) or clause (a.1) of the definition "Category A offence" in subsection 264(1),

(i.1) an offence referred to in any of the following provisions of the definition "Category B offence" in that subsection:

(A) subclauses (a)(vii) to (viii.2), or

(B) clauses (a.1) to (a.3), or

Madam Chairperson: The honourable Minister of–are there are any–oh–

It has been moved by the honourable Minister of Justice, that–

Some Honourable Members: Dispense.

Madam Chairperson: The amendment is in order. The floor is open for questions.

Mr. Chomiak: And I knew you'd catch that.

The–I should indicate that we did distribute these amendments to the opposition critic several days ago for purposes of, of concurrence, and, as I indicated earlier, we had actually anticipated four amendments and–but to be precise and accurate, we, we can only propose these two.

And the second one is the purpose of the clause four in Bill 11 is to update the mandatory post-suspension ignition interlock provisions of The Highway Traffic Act to reflect the change that was made in the federal Bill C-2 to the numbering of the impaired driving offence section of the Criminal Code, because those sections change by virtue of numbering. And the committee amendment modifies clause 4 by adding provisions that are necessary in order to ensure that the mandatory post-suspension ignition interlock requirement will be applied to the new impaired driving offences created by federal Bill C-2.

Madam Chairperson: Any other questions?

Is the committee ready for the question?

Some Honourable Members: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 4 as amended pass?

Some Honourable Members: Pass.

Madam Chairperson: Shall clauses 5 and 6 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clause 4 as amended is accordingly passed.

Shall clauses 5 and 6 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clause 5 and 6 are accordingly passed.

Shall clause 7 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clause 7 is accordingly passed.

Shall the enacting clause pass?

Some Honourable Members: Pass.

Madam Chairperson: The enacting clause is accordingly passed.

Shall the title pass?

***** (22:30)

Some Honourable Members: Pass.

Madam Chairperson: The title is accordingly passed.

Shall the bill be reported?

Some Honourable Members: Agreed.

Madam Chairperson: Agreed. The bill shall be reported–bill shall be reported as amended.

Just go briefly back to Bill 11. Shall the bill, as amended, be reported?

Some Honourable Members: Agreed.

Madam Chairperson: Agreed. The bill shall be reported as amended.

Bill 13–The Medical Amendment Act

Madam Chairperson: We'll move on to Bill 13, The Medical Amendment Act.

Does the minister responsible for Bill 13 have an opening statement?

Hon. Theresa Oswald (Minister of Health): No, thank you, Madam Chair.

Madam Chairperson: Thank the minister.

Does the critic from the official opposition have an opening statement?

Mrs. Myrna Driedger (Charleswood): I'll forgo it, and just to indicate that we're supportive of the legislation and the innovation that it brings to health care.

Madam Chairperson: Thank you very much.

Shall clauses 1 through 3 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 1 through 3 are accordingly passed.

Shall clause 4 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clause 4 is accordingly passed.

Shall clauses 5 and 6 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 5 and 6 are accordingly passed.

Shall the enacting clause pass?

Some Honourable Members: Pass.

Madam Chairperson: The enacting clause is accordingly passed.

Shall the title pass?

Some Honourable Members: Pass.

Madam Chairperson: The title is accordingly passed.

Shall the bill be reported?

Some Honourable Members: Agreed.

Madam Chairperson: Agreed. The bill shall be reported.

Bill 18–The Regulated Health Professions Act

Madam Chairperson: Moving on to Bill 18, The Regulated Health Professions Act.

Does the minister responsible for Bill 18 have an opening statement?

Hon. Theresa Oswald (Minister of Health): Yes, thank you, Madam Chair. I do have a few opening comments.

Certainly, the presenters we've heard over the last couple of evenings add to a lengthy and thorough consultation process, and I want to thank everybody who has come to offer their articulate and insightful comments. We've heard several people recognize the legislative unit in the Department of Health and Healthy Living. I want to be on the record, absolutely, in extending my most sincere apprec–appreciation to Heather McLaren, Donna Hill and Barb Millar for their hard work and dedication to the consultation.

Madam Vice-Chairperson in the Chair

I also want to recognize the staff from Manitoba Justice who have provided important advice and drafted a very important bill to modernize the regulation of health professions. Thank you goes to Christina Wasyliw, Glen McLeod and Gail Mildren.

Bill 18 is, of course, a product of a lengthy consultation process of nearly three years. We've continued to receive important feedback after the formal consultation process closed in March and, indeed, here at committee for the last two evenings.

Accordingly, I will signal to the committee that we will be introducing several amendments based on much of what we have heard. As the act is quite lengthy and complex, several amendments in different parts of the act are required for, essentially, a single issue which would account essentially for the number of amendments we need to bring forward.

As I have stated before, we will remain open to making a change on the issue presented repeatedly from the pharmacists of Manitoba, and we will continue to offer support to the Manitoba Pharmaceutical Association, the independent regulatory body for pharmacists and the various pharmacy stakeholder groups with the hope of coming to a consensus on these important issues.

We are going to propose amendments tonight to change the current name for the dentists' regulatory body from the currently proposed College of Dentists and Dental Assistants of Manitoba to the College of Dentists of Manitoba, as the Manitoba Dental Association requested in their presentation last night. This is one amendment that requires several amendments throughout the bill, for which I'll humbly apologize to the committee.

We will be proposing several amendments related to the issue of publishing the names and details of health professionals who have been censured, voluntarily surrendered their licence to practice, or disciplined for an ailment, emotional disturbance or addition–or addiction–that affects their ability to practice. This will recognize the right to privacy while allowing a college to publish the name if there, there is an unlikely event that public interest substantially outweighs the individual's right to privacy for these health-related issues. Employers must still be notified in these situations, and the disciplinary information will still appear on the register which is available to the public.

Finally, we'll be proposing several minor amendments to clarify language on a number of issues, most of which were identified by the College of Physicians and Surgeons of Manitoba.

Madam Vice-Chairperson: We thank the minister.

Does the critic from the official opposition have an opening statement?

Mrs. Myrna Driedger (Charleswood): Just some–a few comments to be made. I'm glad to certainly hear about the amendments that the minister is bringing forward. I think that, you know–particularly the one that was addressed by Sandi Mowat in terms of the di–disciplinary process for, for naming people I think was a significant comment and I was glad to see that that was recognized.

Madam Chairperson in the Chair

I, I, too, want to thank everybody for their presentations. I think the presenters that came were all very committed to seeing good legislation. They were all very credible. They all presented their positions extremely well. And I think, you know, generally what we saw was, you know, people approving this legislation in principle and wanting to move ahead to strengthen health care.

I, I do note and I was glad to hear the minister clarify some of the concerns raised about public representation and I was glad to hear that has been addressed. I have to say, I'm very troubled to hear about the divisions in the pharmacy profession. It became more obvious tonight that these divisions have been there for some period of time now.

I have to indicate that I am troubled that the Minister of Health didn't intervene sooner than, than she did. I think had Pricewaterhouse been brought in, you know, much sooner than they were, that I, I

think it could have lessened some of the, the issues that are out there. I think that the situation has worsened because of that. She referred to the relationship amongst pharmacists as a war. I'm not sure I would go that far, but I do acknowledge that the profession is being torn apart by the divisions within it. And I think the minister dropped the ball on this issue, and I think, you know, having some intervention earlier on and acting sooner might have helped to relieve some of these tensions. And I, and I think that there is a responsibility that rests with her to help move this along.

And, you know, I know in the past she said that she doesn't spend a lot of time listening to what opposition says, but I hope that she will heed this suggestion and, you know, work and, and find ways to help mediate the situation so that we can see this profession come together to, to, you know, find their place, you know, amongst health profe–all the other health professions, and, you know, everybody will, will be able to move forward.

So, with those few comments, I'll leave it at that.

Madam Chairperson: Thank you. Due to the size and structure of Bill 18, is it the will of the committee to consider the bill in blocks of clauses corresponding to its 18 parts, with the understanding that we will stop at any particular clause or clauses where members may have comments, questions or amendments to propose. Is it agreed?

Some Honourable Members: Agreed.

Madam Chairperson: It is agreed.

We'll start with part 1, pages 1 to 4. Shall clause 1 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clause 1 is accordingly passed.

Part 2, pages 5 to 14, shall clauses 2 through 7 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 2 through 7 are accordingly passed.

Part 3, pages 15 to 21, shall clauses 8 through 25 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 8 through 25 are accordingly passed.

Part 4, pages 22 to 36, shall clauses 26 and 27 pass?

Some Honourable Members: Pass.

***** (22:40)

Madam Chairperson: Clauses 26 and 27 are accordingly passed.

Shall clause 28 pass?

Ms. Oswald: I move that clause 28, sub 1, sub g, of the bill be replaced with the following: (g), information about each disciplinary proceeding in which a finding under subsection 124, sub 2 or clause 131, sub 1, sub b, has been made against the member, including: (i), the nature of the following, nature of the finding rather; (2), the nature of any order made under section 126, 127 or 131; and (3), any terms, limits or conditions of the order.

Madam Chairperson: It has been moved by the honourable Minister of Health that clause 28–dispense?

An Honourable Member: Dispense.

Madam Chairperson: Dispense.

The amendment is in order. The floor is open for questions.

Ms. Oswald: This amendment clarifies the information to be placed on the register for regulated members, also related to the upcoming amendments to section 129 regarding restricting publication of disciplinary decisions involving findings about addictions, ailments and emotional disturbances.

Madam Chairperson: Are there any other questions?

Seeing none, is the committee ready for the question?

Some Honourable Members: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 28 pass as amended? *[interjection]* Oh, there's–sorry.

Ms. Oswald: I move that clause 28, sub 2, sub f of the bill be replaced with the following: (f), information about each disciplinary proceeding in

which a finding under subsection 124, sub 2, or clause 131, sub 1, sub b, has been made against the associate member including: (i), the nature of the finding; (ii), the nature of any order made under section 126, 127 or 131; and (iii), any terms, limits or conditions of the order.

Madam Chairperson: It has been moved by the honourable Minister of Health that clause 28(2)(f) of the bill be–dispense?

An Honourable Member: Dispense.

Madam Chairperson: Dispense.

The amendment is in order. The floor is open for questions.

Ms. Oswald: This is–the reason for this is the same as the previous reasoning but it regards associate members.

Madam Chairperson: Thank you very much. Are there any other questions?

Seeing none, is the committee ready for the question?

Some Honourable Members: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Ms. Oswald: I move that clauses 28, sub 3, sub b and sub c of the bill be replaced with the following: (b), the information described in the clause 1, sub g or 2, sub f, relating to a disciplinary proceeding completed within the current calendar year or the 10 previous calendar years.

Madam Chairperson: It has been moved by the Minister of Health that–dispense?

An Honourable Member: Dispense.

Madam Chairperson: The amendment is in order. The floor is open for questions.

Ms. Oswald: This amendment assures that the register must contain information from the current year and the previous 10 years about disciplinary actions.

Madam Chairperson: Are there any questions?

Seeing no other questions, is the committee ready for the question?

Some Honourable Members: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Ms. Oswald: I move that the following be added after clause 28, sub 3 of the bill: information not to be available on the Internet; 28, sub 4: information that is available to the public under subsection 3 and that relates to an ailment, emotional disturbance or addiction that a member is suffering from or has suffered from must not be made available to the public on the Internet.

Madam Chairperson: It has been moved by the honourable Minister of Health that the following be added–dispense?

An Honourable Member: Dispense.

Madam Chairperson: Dispense.

The amendment is in order. The floor is open for questions.

Ms. Oswald: I believe that amendment's self-explanatory.

Madam Chairperson: Are there any other questions?

Hon. Jon Gerrard (River Heights): Just to clarify the intent of this, is the intent that the information would be available to the public but not on the Internet, in other words, by application to the college or whatever?

Ms. Oswald: That's correct. The information would be on the register but not on-line on the Web site.

Madam Chairperson: Are there any other questions?

Is the committee ready for the question?

An Honourable Member: Question.

Madam Chairperson: Shall the amendment pass?

An Honourable Member: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 28 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 28, as amended, is accordingly passed.

Shall clauses 29 through 56 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 29 through 56 are accordingly passed.

Part 5, pages 37 to 50, shall clauses 57 through 76 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 57 through 76 are accordingly passed.

Part 6, pages 51 to 54, shall clause 77 pass?

An Honourable Member: Pass.

Madam Chairperson: Clause 77 is accordingly passed.

Shall clause 78 pass?

Ms. Oswald: Madam Chair, I move that clause 78(3) of the bill be amended in the heading and in the clause by striking out: and dental assistants.

Madam Chairperson: It has been moved by the honourable Minister of Health that clause 78, sub 3– dispense?

An Honourable Member: Dispense.

Madam Chairperson: The amendment is in order. The floor is open for questions.

Ms. Oswald: Madam Chair, this is an amendment that changes the name of the college of dentists and dental assistants of Manitoba to college of dentists of Manitoba, as requested.

Madam Chairperson: Is the committee ready for the question?

An Honourable Member: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 78 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 78, as amended, is accordingly passed.

Shall clauses 79 through 81 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 79 through 81 are accordingly passed.

Part 7, pages 55 to 57, shall clauses 82 through 87 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 82 through 87 are accordingly passed.

Part 8, pages 58 to 90, shall clauses 88 through 97 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 88 through 97 are accordingly passed.

Shall clause 98 pass?

Ms. Oswald: Madam Chair, I move that clause 98, sub 3 of the bill be amended by striking out: the council considers necessary to assist the investigator and substituting the investigator considers necessary to assist him or her.

Madam Chairperson: It's been moved by the honourable Minister of Health that clause 98, sub 3– dispense?

An Honourable Member: Dispense.

Madam Chairperson: Dispense.

The amendment is in order.

Ms. Oswald: Yes, this amendment clarifies that the council may engage legal counsel that the investigator considers necessary, and the council does not need to involve itself in the details of the investigation in order to engage legal counsel.

Madam Chairperson: There any other questions?

Is the committee ready for the question?

An Honourable Member: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 98 pass as amended?

An Honourable Member: Pass.

Madam Chairperson: Clause 98, as amended, is accordingly passed.

Shall clause 99 pass?

Ms. Oswald: Madam Chair, I move that clause 99, sub 1 of the bill be amended in the part after clause (f) by adding: or if it is necessary to protect the public from exposure to serious risk, on the direction of the chair of that committee, at the end.

Madam Chairperson: It has been moved by the honourable Minister of Health that clause 99, sub 1–dispense?

An Honourable Member: Dispense.

Madam Chairperson: The amendment is in order.

Ms. Oswald: Madam Chair, this clarifies the intent of the provisions. In urgent matters, the chair of the complaints investigative committee may direct the investigator to use certain inspection powers.

Madam Chairperson: There any other questions? Seeing none, is the committee ready for the question?

An Honourable Member: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 99 pass as amended?

An Honourable Member: Pass.

Madam Chairperson: Clause 99, as amended, is accordingly passed. Shall clause 100 pass?

An Honourable Member: Pass.

Madam Chairperson: Clause 100 is accordingly passed.

Shall clause 101 pass?

Ms. Oswald: Madam Chair, I move that clause 101, sub 2 of the bill be amended by striking out: written submissions about the findings in the report, and substituting: a written submission, under subsection 102, sub 2.

Madam Chairperson: It's been moved by the honourable Minister of Health that clause 101, sub 2–dispense?

An Honourable Member: Dispense.

Madam Chairperson: The amendment is in order.

***** (22:50)

Ms. Oswald: Yes, Madam Chair, this clarifies that the written submission is the same written submission referred to in subsection 102, sub 2.

Madam Chairperson: Any other questions?

Is the committee ready for the question?

Some Honourable Members: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed. Shall clause 101 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 101 as amended is accordingly passed.

Shall clauses 102 and 103 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 102 and 103 are accordingly passed.

Shall clause 104 pass?

Ms. Oswald: Madam Chair, I move that clause 104, sub 2 of the bill be replaced with the following: Censure may be made publicly available, 104, sub 2, subject to subsection 2.1, the complaints investigation committee may make available to the public the name of an investigated member who has been censured and a description of the circumstances that led to the censure. Censure relates to ailment, addiction, et cetera. 104, 2–sub 2.1. If, in agreeing to accept a censure, the investigated member admits to suffering from an ailment, emotional disturbance or addiction that impairs his or her ability to practice the regulated health profession, the complaints investigation committee (a) must not make any information about the investigated member or the censure available under subsection 2, and (b) may inform an employer, person or entity referred to in section 133 of the censure and provide a description of the circumstances that led to it.

Madam Chairperson: Thank you. It's been moved by the honourable Minister of Health that–

Some Honourable Members: Dispense.

Madam Chairperson: Dispense.

The amendment is in order. The floor is open for questions.

Ms. Oswald: Madam Chair, information about censures may be made publicly available except for censures where a member has admitted that he or she suffers from an ailment, addiction or emotional disturbance that affects the member's ability to practice, and it maintains that employers may be notified.

Madam Chairperson: Are there any other comments or questions?

Mrs. Driedger: Just a qu–just a question, and it would be related to whether or not the person that is being censured, if the person is not prepared to go along with treatment, does it still reach a point if the member does not seek help and seek treatment, that there is, then, the making of the name public?

Ms. Oswald: They need to, in these circumstances, admit to the issue and agree to the censure.

Madam Chairperson: Are there any other questions?

Mr. Gerrard: Just a clarification on why you would put may inform rather than must inform an employer?

Ms. Oswald: Madam Chair, the, the whole issue of publication is discretionary.

Madam Chairperson: Are there any other questions?

Mr. Gerrard: This is, I'm presuming, where you're talking about, may inform an employer, that this is not public publication, but that this is information direct to the employer.

Ms. Oswald: Thank you for the opportunity to clarify. At this point in the amendment it's, it's a censure, you know, as, as described by legal counsel, you know, a, a reprimand. It, it hasn't gone to the stage of a, a disciplinary action, so there's opportunity essentially to make amends at this stage of the game. Later, in the situation where disciplinary action is being taken, it's a different matter.

Madam Chairperson: Are there any other questions?

Mr. Gerrard: You know, I'm just sort of hesitating here because if, if you've got somebody who is censured, then there is obviously going to be an immediate question about whether they continue in their existing capacity working in the health-care field or not, right? I mean, that these two are not exactly completely separate, you know. I mean if, if you have a censure for, whether it be a nurse or pharmacist or doctor, you know, because of alcoholism, for example, then, I mean you presumably can't have censure without some action at the same time. That would–

Ms. Oswald: Yes, at this point in the process, and it is a process that–an extensive one–that the college goes through with the individual, there are several options that the college has to consider at this point about how to address the specific issue, censure being one of them. And if the college elects to choose censure at this point, it is with the understanding that indeed the in–the individual can continue to safely practise. And so that's why it's, it's written as it is.

There are amendments upcoming that may clarify the issue further, but their decision to censure at this point is also a decision that the practice of safe care shan't be impeded.

Madam Chairperson: Are there any other questions?

Seeing none, is the committee ready for the question?

Some Honourable Members: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 104 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 104 as amended is accordingly passed.

Shall clause 105 pass?

The honourable Minister of Health.

Ms. Oswald: Madam Chair, I move that clause 105 (3) of the bill be replaced with the following: voluntary surrender may be made publicly available 105(3) subject to subsection 4, the complaints investigation committee may make available to the public the name of the investigated member, the fact that the member has voluntarily surrendered his or her registration or certificate of practice and a

description of the circumstances that led to the voluntary surrender. Voluntary surrender relates to ailment, addiction, et cetera; 105 (4) if in agreeing to voluntary surrender, his or her resig–registration or certificate of practice, the investigated member admits to suffering from an ailment, emotional disturbance or addiction that impairs his or her ability to practise the regulated health profession, the complaints investigation committee (a) must not make any information about the investigated member or the voluntary surrender available under subsection 3, and must inform an employer, person or entity referred to in section 133 of the voluntary surrender and provide a description of the circumstances that led to it.

Madam Chairperson: Okay, we'll just make sure that it is as printed. There's just omitted the second "b" as I understand it, so we'll just have it as printed.

THAT Clause 105(3) of the Bill be replaced with the following:

Voluntary surrender may be made publicly available
105(3) *Subject to subsection (4), the complaints investigation committee may make available to the public the name of the investigated member, the fact that the member has voluntarily surrendered his or her registration or certificate of practice and a description of the circumstances that led to the voluntary surrender.*

Voluntary surrender relates to ailment, addiction, etc.
105(4) *If, in agreeing to voluntarily surrender his or her registration or certificate of practice, the investigated member admits to suffering from an ailment, emotional disturbance or addiction that impairs his or her ability to practise the regulated health profession, the complaints investigation committee*

(a) must not make any information about the investigated member or the voluntary surrender available under subsection (3); and

(b) must inform an employer, person or entity referred to in section 133 of the voluntary surrender and provide a description of the circumstances that led to it.

Madam Chairperson: It's been moved by the honourable Minister of Health that clause 1–

An Honourable Member: Dispense.

Madam Chairperson: Dispense.

The amendment is in order. The floor is open for questions.

Ms. Oswald: Yes, Madam Chair, this information about voluntary surrenders may be, may be made publicly available except for voluntary surrenders that involve the member admitting that he or she suffers from an ailment, addiction or emotional disturbance that affects the member's ability to practise, and it's clear here that employers must be notified given their obligation to ensure members are registered and certified to practise.

Madam Chairperson: Thank you. Any other questions? Is committee ready for the question?

Some Honourable Members: Question.

Madam Chairperson: Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Madam Chairperson: Shall clause 105 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 105 as amended is accordingly passed.

Shall clauses 106 through 128 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 106 through 128 are accordingly passed.

Shall clause 129 pass? The honourable Minister of Health.

Ms. Oswald: Madam Chair, I move that clause 129(1) of the bill be amended by striking out: subject to subsection 2, and substituting: subject to subsections 2 and 3.

Madam Chairperson: It's moved by the honourable Minister of Health that clause 129 sub–

Some Honourable Members: Dispense.

Madam Chairperson: Dispense.

The amendment is in order.

***** (23:00)

Ms. Oswald: Subsection 1 now refers to both of the conditions restricting publication of disciplinary decisions. That is the addictions issue.

Madam Chairperson: Are there any other questions?

Is the committee ready to vote?

Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Ms. Oswald: I move that the following be added after clause 129, sub 2 of the bill: If ailment, emotional disturbance or addiction impairs member's ability to practice: 129, sub 3: If a finding has been made under clause 124, sub 2, sub g, the college, when making information available to the public under subsection 1, must not make available to the public (a) the name of the investigated member, or (b) any personal health information about the investigated member, unless the college is satisfied that the public interest in making the information available to the public substantially outweighs the privacy interests of the investigated member. In this subsection, personal health information means personal health information as defined in The Personal Health Information Act.

Madam Chairperson: It's been moved by the honourable Minister of Health that the following be added after clause–dispense?

An Honourable Member: Dispense.

Madam Chairperson: The amendment is in order.

Ms. Oswald: The new subsection 3 prohibits the publication of a member's name or personal health information if a finding has been made about his or her addiction, emotional disturbance or ailment, unless the public interest substantially outweighs the member's privacy interests.

Madam Chairperson: Is the committee ready for the question?

Mrs. Driedger: For clarification, because you've made reference in there to The Personal Health Information Act, does that actually prevent any information then from coming forward? Because the, you know, the PHIA legislation is fairly strong in its, in its wording. So, does that mean that nothing can come forward? Or, as we go, you know, above it, if it outweighs the privacy interest that we can put it forward, but otherwise I just know that that legislation is, is fairly strong in its language. So, by putting it in there, do you actually prevent a person's information from being made public?

Ms. Oswald: It's just providing a, a definition, but it's not providing, you know, a legislative barrier to releasing information in those situations where the public interest substantially outweighs the privacy of the individual.

Madam Chairperson: Are there any other questions?

Shall the amendment pass? Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Ms. Oswald: I move that the following be added after clause 129 of the bill but before the centred heading: Appeal of decision under subsection 129, sub 3: 129.11, If the college intends to make information available to the public under subsection 129, sub 3, the college (a) must give notice of its intention to the investigated member and advise the investigated member of his or her right to appeal the decision as set out in this section, and (b) must not make any information described in clause 129, sub 3, sub a or sub b available to the public under subsection 129, sub 1 until the time period described in subsection 2 has lapsed, or, if an appeal has been filed, the investigated member's appeal is exhausted.

Notice of appeal: 129.1, sub 2, An investigated member may appeal a decision by filing within 10 days after receiving notice from the college under clause 1, sub a, a notice of appeal with the court.

Copy of notice must be given to the college: 129.1, sub 3, The investigated member must, without delay, give a copy of the notice of appeal to the college, and the college is a party to the appeal.

Decision of the court: 129.1, sub 4, After hearing an appeal under this section, the court may confirm, reverse or vary the college's decision to make the information available to the public.

Court to protect privacy: 129.1, sub 5, On an appeal the court must take reasonable precautions to protect the investigated member's privacy including his or her identity which may include receiving representations ex parte, conducting hearings in private and examining records in private.

Madam Chairperson: It's been moved by the honourable Minister of Health–dispense?

An Honourable Member: Dispense.

Madam Chairperson: The amendment is in order.

Ms. Oswald: Clearly, this section–thank you, Madam Chair. Clearly, this section concerns a member's right to appeal.

Mr. Chomiak: I'm sorry, I like it when it's not my bill and I can interpret it, but I, I, I just wanna–we've gone through a series of amendments going from censure to disciplinary hearing to Court of Appeal hearing, where the rights of the individual, from a medical or an addictive standpoint, have protection from disclosure if, in the case of censure, if they, if they admit to and get the treatment; in the case of disciplinary, if the public interest is not dramatically affected by it, and then in the court, when you get to the court system where the court system feels that, where the court system has the, the ability to think that it's not in the interest.

So you see the process going through that the right to protection from those measures have been protected at the various stages of the processes and that's the only point I wanted to make and it varies as you go through the system 'cause when you get to the court system it's–you can only say reasonable precaution to the court but in the ques–in the kes–in the case of the discipline, it's you know, substantial public interest, but I just like doing this stuff. You know, I don't have to do it directly and I can just comment on it.

It's, it's the idea of just this, this, this spectrum, 'cause I know members are concerned that this is a big issue and you can see that it's just formed right through to take, take a process through. It's fun.

Madam Chairperson: Thank you. Any other comments or questions?

Is the committee ready for the question?

Some Honourable Members: Question?

Madam Chairperson: Shall the amendment pass?

An Honourable Member: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 129 pass as amended?

An Honourable Member: Pass.

Madam Chairperson: Clause 129, as amended, is accordingly passed.

Shall clauses 130 through 133 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 130 through 133 are accordingly passed.

Part 9, pages 91 to 103, shall–

An Honourable Member: Pass.

Madam Chairperson: –shall clauses 134 through 143 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 134 through 143 are accordingly passed.

Part 10, pages 104 to 107, shall clauses 144 through 154 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 144 through 154 are accordingly passed.

Part 11, pages 108 to 112, shall clauses 155 through 162 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 155 through 162 are accordingly passed.

Part 12, pages 113 to 116, shall clause, shall clauses 163 through 165 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 163 through 165 are accordingly passed.

Part 13, pages 117 to 121, shall clauses 166 through 177 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 166 through 177 are accordingly passed.

Part 14, pages 122 to 133, shall clauses 178 through 186 pass? Pass?

Some Honourable Members: Pass.

Ms. Oswald: Sorry.

An Honourable Member: I apologize I was interrupting.

Madam Chairperson: This is part 14.

Ms. Oswald: I stand corrected, Madam Chair, carry on.

Madam Chairperson: Shall clauses 178 through 186 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 178 through 186 are accordingly passed.

Part 15, pages 134 to 165, shall clauses 187 and 188 pass?

An Honourable Member: Pass.

Madam Chairperson: Clauses 187 and 188 are accordingly passed.

Shall clause 189 pass?

Ms. Oswald: Madam Chair, I move that clause 189, sub 1, sub d of the bill be replaced with the following: (d) information about each disciplinary proceeding in which a finding under subsection 124, sub 2 or clause 131, sub 1, sub b, has been made against the owner including (i) the nature of the finding, (ii) the nature of any order made under section 126, 127 or 131 and (iii) any terms, limits or conditions of the order and.

***** (23:10)

Madam Chairperson: It's been moved by the honourable Minister of Health that clause 189, sub–dispense?

Some Honourable Members: Dispense.

Madam Chairperson: The amendment is in order.

Ms. Oswald: This is the same as an earlier amendment we made about what can appear in the register.

Madam Chairperson: Are there any other questions?

Ms. Oswald: Regarding the register for licensed owners of pharmacies, to be more specific. Thank you, Madam Chair.

Madam Chairperson: Are there any other questions?

Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Ms. Oswald: I move that clauses 189, sub 2, sub b and (c), of the bill be replaced with the following: (b) the information described in clause 1, sub d, relating to a disciplinary proceeding completed within the current calendar year or the 10 previous calendar years.

Madam Chairperson: It has been moved by the honourable Minister of Health that clauses 1–dispense?

An Honourable Member: Dispense.

Madam Chairperson: The amendment is in order.

Ms. Oswald: Again, this amendment concerns the register of licensed pharmacy owners, and it concerns the information it must contain and 10 years past.

Mrs. Driedger: Can the minister just clarify her reasoning? I think it used to be–was it five years before and now it's been changed to 10? Can the minister indicate the reason for the change?

Ms. Oswald: Yes. I can inform the member that in the, in the College of Physicians and Surgeons, the move had been made to previous 10 years, and in discussions and consultations among the professions and, certainly, with patient safety advocates, there was great interest in moving to 10 years.

Madam Chairperson: Any other questions?

Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Ms. Oswald: I move that the following be added after clause 189, sub 2, of the bill: information not to be available on the Internet, 189, sub 3: information that is available to the public under subsection 2, and that relates to an ailment, emotional disturbance or addiction that an owner is suffering from or has suffered from must not be made available to the public on the Internet.

Madam Chairperson: It's been moved by the honourable Minister of Health that the following be added after–dispense?

Some Honourable Members: Dispense.

Madam Chairperson: The amendment is in order.

Ms. Oswald: Again, this pertains to the licensed pharmacy owners and the issues we've discussed previously concerning disclosure and addictions.

Madam Chairperson: Any other questions?

Mr. Gerrard: Clarification: From what's happened in the previous sections–and I'm presuming you're going to duplicate that with the rest in relationship to pharmacists–that what this means is that where there is an ailment, emotional disturbance or addiction and, and it's not, you know, it's not sort of kept private, as it were, it becomes public but not public on the Internet. Is that what you're saying?

For instance, where, where you have somebody who doesn't acknowledge–right?–their addiction, for example, you would then make it public. You would make it public, but not on the Internet.

Ms. Oswald: Yes, if I'm understanding your comments correctly. Again, this pertains to information not being on the Web site or on the Internet, but in the case of a disciplinary finding, it, it would be on the register.

Madam Chairperson: There any other questions?

Mrs. Driedger: I guess, just taking that a step further, because right now you can actually go on to the College of Physicians and Surgeons Web site and read their newsletter, and within their newsletter it talks about doctors that have been disciplined, and so it's in their newsletter but it's on their Web site. Now, does that mean that's totally removed then?

Ms. Oswald: This specific amendment relates to the register. The amendments that we made earlier concern the issue of the publication as you referenced, and certainly that has been part of the discourse concerning the nurses issue. So this specifically relates to the register.

Madam Chairperson: Are there any other questions?

Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 189 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 189 as amended is accordingly passed.

Shall clauses 190 through 206 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 190 through 206 are accordingly passed.

Shall clause 207 pass? The honourable Minister of Health.

Ms. Oswald: I move that clause 207, sub 16 of the bill be replaced with the following: 207, sub 16, subsections 105, sub 3 and sub 4 are to be read as follows: Voluntary surrender may be made publicly available 105, sub 3 subject to subsection 4, the complaints investigations committee may make available to the public the name of the investigated member, the fact that the investigated member has voluntarily surrendered his or her registration certificate of practice, or pharmacy licence, as the case may be, and a description of the circumstances that led to the voluntary surrender. Voluntary surrender relates to ailment, addiction, et cetera; 105, sub 4: if an investigated member, in agreeing to voluntarily surrender his or her registration certificate of practice, or pharmacy licence as the case may be, admits to suffering from an ailment, emotional disturbance or addiction that impairs his or her ability to practise the regulated health profession or operate a pharmacy, the complaints investigation committee: (a) must not make any information about the investigated member or voluntary surrender available under subsection 3; and, (b) must inform an employer, person or entity referred to in section 133 or 133.1 of the voluntary surrender and provide a description of the circumstances that led to it.

Madam Chairperson: It's been moved by the honourable Minister of Health–dispense?

An Honourable Member: Dispense.

Madam Chairperson: The amendment is in order.

Ms. Oswald: The subsection 105, sub 3, and 105, sub 4, are to be read in part 15 as applying to owners of licensed pharmacy. The information about voluntary surrenders, you know, as stated in the bill concerns issues around addiction. Employers must be notified, given their obligation to ensure members are registered and certified to practise.

Madam Chairperson: Any other questions? Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 207 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 207 as amended is accordingly passed.

Shall clauses 208 through 217 pass? Shall clauses 208 through 217 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 208 through 217 are accordingly passed.

Part 16, pages 166 to 181, shall clauses 218 and 219 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 218 and 219 are accordingly passed.

Shall clause 220 pass? The honourable Minister of Health.

Ms. Oswald: Madam Chair, I move that clause 220, sub 1, sub e, (e), of the bill be amended by striking out: and dental assistants.

Madam Chairperson: It's been moved by the honourable Minister of Health that–

Some Honourable Members: Dispense.

Madam Chairperson: Dispense.

The amendment is in order. The honourable Minister of Health.

Ms. Oswald: Self-explanatory, Madam Chair.

Madam Chairperson: Any questions? Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 220 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 220 as amended is accordingly passed.

Shall clause 221 pass?

The honourable Minister of Health.

Ms. Oswald: Love the dentists. I move–okay, don't put that part in, sorry–I move that clause 221, sub 3, of the bill be amended in the heading and in the part before the clause (a) by striking out: and dental assistants.

Madam Chairperson: It's been moved by the honourable–oh–*[interjection]*

So can we agree that that amendment will be as printed? Is that agreed?

***** (23:20)

Some Honourable Members: Agreed.

Madam Chairperson: Agreed. That's agreed.

THAT Clause 221(3) of the Bill be amended in the heading and in the part before clause (a) by striking out "and Dental Assistants".

It's been moved by the honourable Minister of Health that clause 221 sub–dispense?

Some Honourable Members: Dispense.

Madam Chairperson: The amendment is in order.

Ms. Oswald: Well, I didn't flinch.

Madam Chairperson: Any questions. Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 221 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 221 as amended is accordingly passed.

Part 17, pages 182 to 197, shall clauses 222 through 232 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 222 through 232 are accordingly passed.

Shall clause 233 pass?

Ms. Oswald: I move that the proposed item 15 as set out in clause 233 of the bill be amended by striking out: and dental assistants.

Madam Chairperson: It's been moved by the honourable Minister of Health that the–dispense?

An Honourable Member: Dispense.

Madam Chairperson: Any questions?

Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 233 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 233 as amended is accordingly passed.

Shall clauses 234 through 236 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 234 through 236 are accordingly passed.

Shall clause 237 pass?

Ms. Oswald: I move that the proposed definition practising dentist in the English version as set out in clause 237, sub 2, sub c of the bill be amended by striking out: and dental assistants.

Madam Chairperson: It's been moved by the honourable Minister of Health–dispense?

Some Honourable Members: Dispense.

Madam Chairperson: Any questions?

Shall the amendment pass?

Some Honourable Members: Pass.

Madam Chairperson: The amendment is accordingly passed.

Shall clause 237 pass as amended?

Some Honourable Members: Pass.

Madam Chairperson: Clause 237 as amended is accordingly passed.

Shall clauses 238 through 259 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 238 through 259 are accordingly passed.

Part 18, page 198, shall clauses 260 through 262 pass?

Some Honourable Members: Pass.

Madam Chairperson: Clauses 260 through 262 are accordingly passed.

Schedule 1 page 199, shall schedule 1 pass?

Some Honourable Members: Pass.

Madam Chairperson: Schedule 1 is accordingly passed.

Schedule 2, page 200, shall schedule 2 pass?

Some Honourable Members: Pass.

Madam Chairperson: Schedule 2 is accordingly passed.

Shall the table of contents pass?

Some Honourable Members: Pass.

Madam Chairperson: The table of contents is accordingly passed.

Shall the enacting clause pass?

Some Honourable Members: Pass.

Madam Chairperson: The enacting clause is accordingly passed.

Shall the title pass?

Some Honourable Members: Pass.

Madam Chairperson: The title is accordingly passed.

Shall the bill as amended be reported?

Some Honourable Members: Agreed.

Madam Chairperson: Agreed. The bill shall be reported as amended.

I think we all want to say a thank you to all the staff who have stuck through this process with us. Thank you very much for all your work.

The hour being 11:24, what is the will of the committee?

Some Honourable Members: Rise.

Madam Chairperson: Committee rise.

COMMITTEE ROSE AT: *11:24 p.m.*

WRITTEN SUBMISSIONS PRESENTED BUT NOT READ

Re: Bill 18

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

* * *

Dear Ms Howard:

Ms Jennifer Howard
MLA, Fort Rouge
Chair, Standing Committee on Human Resources
Legislative Assembly of Manitoba

Re: Bill 18 -*The Regulated Health Professions Act*

The Canadian Medical Protective Association ("CMPA") welcomes this opportunity to make submissions to the Standing Committee on Human Resources (the "Standing Committee") regarding Bill 18, The Regulated Health Professions Act (the "Bill") concerning the regulation and discipline of regulated health professionals in Manitoba.

CMPA

As the principal provider of medico-legal assistance to Manitoba physicians, the CMPA can foresee the important ramifications that the proposed legislation will have on Manitoba physicians. The CMPA has been actively involved in similar initiatives in other provinces aimed at reforming the legislative framework around the regulation of health professions. As such, the CMPA is uniquely positioned to offer the Standing Committee a broad perspective based on its national experience with the issues raised by Bill 18.

The CMPA is a not-for-profit mutual defence organization run for and by Canadian physicians. It is the principal provider of medico-legal assistance to Canadian physicians, including approximately 2,700 Manitoba physicians. The most obvious expression of the CMPA's assistance to its members is the provision of legal representation, including the payment of legal costs, judgments or settlements to compensate patients with meritorious claims. It is equally significant that the CMPA provides broader advisory services to its members on a multitude of medico-legal issues, including advising on matters before regulatory bodies. Consequently, any legislative changes to the regulation of physicians and other health professionals will have important implications for the CMPA and its Manitoba members.

Summary of CMPA Recommendations

In February, the CMPA responded to an invitation from Manitoba Health and Healthy Living (the "Ministry") to comment on its publication, The Health Professions Regulatory Reform Consultation Document, dated January 2009, which included an early draft of the legislation later introduced as Bill 18.

While the CMPA was pleased that some of the issues it raised during the consultation process were addressed by the Ministry in the final draft of Bill 18, the CMPA continues to have serious concerns with some parts of the proposed legislation. Many of these concerns were discussed in detail in the submissions to the Ministry, dated February 23, 2009 (attached). Although the section numbers in Bill 18 may have changed since the consultation draft, many of the substantive comments remain applicable to the Bill currently before the Standing Committee.

Rather than repeat in detail the CMPA's position on all of the issues raised in the consultation process, the CMPA instead wishes to focus its submissions to the Standing Committee on the following three issues that are most in need of attention in Bill 18:

- Sections 40 and 41 should be amended to recognize CMPA membership as an acceptable means of "professional liability protection". The term currently proposed, "professional liability insurance", does not incorporate physicians' CMPA membership, which is not "insurance".

- The member should be entitled to an opportunity to respond to the decision of the inquiry committee making an ancillary order pursuant to subsection 126(3), particularly when a new panel is convened to hear a complaint without an investigation. Moreover, subsection 126(6) would permit council, without any evidence or submissions by the member, to cancel or suspend a member's registration or certificate of practice upon finding that the member has breached

an order. It is recommended that subsection 126(6) be deleted.

• Subsection 119(1) should be amended to continue to provide (as is currently stated in *The Medical Act*) that a member whose conduct is the subject of the hearing is not a compellable witness in any proceeding before the inquiry committee. Although the CMPA would state otherwise, it could be argued that "any person" in this section could include the member under investigation.

In its submissions to the Ministry in response to the consultation draft, the CMPA commented in detail on the following additional issues that remain a concern in Bill 18:

• Amendments to the public content of the College register or website should not be left to the College by-laws or Regulations. Such changes should only be made through amendments to the legislation. In this regard, subsection 28(1)(h), allowing the information included on the College's register to be expanded by Regulation, should be deleted.

• The College should not be permitted to publish the circumstances of a member's voluntary surrender of his/her registration as proposed in subsection 105(3) or unresolved malpractice "claims" pursuant to subsection 136(3)(a)(viii). These sections should be deleted.

• The College should be restricted from publishing any information about a member, including following interim action against the physician pursuant to section 133, until the allegations have been proven and the member has been afforded due process.

• Section 112, which authorizes the College to disclose information about the member to a law enforcement agency when it has reasonable grounds to believe the member is engaged or engaging in criminal activity, should be amended to provide appropriate safeguards to limit the information that can be provided to the police (*i.e.* only that which is directly related to the activity in question) and the uses to which evidence collected in the course of a College investigation can be used for this purpose.

• Section 97 should require the College to provide the member who is the subject of the complaint with notice of the complaint and a copy of the complaint submitted by the complainant. The member's right to be informed ought not to be limited to "reasonable particulars" nor should the registrar be entitled to without particulars.

• Members should be afforded an expedited hearing before any interim suspension is ordered pursuant to section 110. In addition, an interim suspension should not be ordered absent reasonable and probable grounds to believe that the member poses a serious risk to patient safety and that urgent intervention is required.

• Section 125 concerning "deemed professional misconduct" for discipline action in other jurisdictions should be deleted.

• The College's authority to require any person to answer questions in subsection 99(1)(f) must be amended to reconcile the potential conflict of such a provision with the physician’s duty of confidentiality to protect the personal health information of their patients.

• Section 115(1) should require the appointment of a retired judge or other respected senior member of the legal profession to each inquiry committee.

• The Act should include a means to enforce time limits proposed in section 116 concerning when the inquiry committee must commence its hearing and in subsection 128(1) that entitles the member and the complainant to written notice and reasons within 90 days after a hearing.

Mandatory Liability Protection

Sections 40 and 41 of Bill 18 address the process by which the Colleges would certify members to practice. Amongst other things, subsections 40(1)(c) and 41(1)(c) would require "regulated members" and "regulated associate members" to "provide evidence of having the amount and type of professional liability insurance or coverage, if any, required by the regulations."

The CMPA respectfully requests that the Standing Committee recommend that sections 40 and 41 be amended to require as a condition of certification that members have adequate professional liability insurance or membership in a professional liability protection association as stated currently in Regulation 25/2003. Otherwise, Manitoba physicians who are members of the CMPA and meeting current regulatory requirements may be deemed to be practicing in contravention of the Act if it is passed in its current form.

Subsection 19(g) of The Medical Act currently authorizes Council of the College of Physicians and Surgeons of Manitoba ("CPSM") to make regulations respecting "professional liability coverage, or other

liability protection". In this regard, Manitoba Regulation 25/2003 concerning the Registration of Medical Practitioners states:

13(1) Every licensed member must possess and maintain professional liability coverage that extends to all areas of the member's practice, through either or both of:

(a) membership in the Canadian Medical Protective Association;

(b) a policy of professional liability insurance issued by a company licensed to carry on business in the province, that provides coverage of at least $10,000,000.

As stated above, the CMPA is a mutual-defence organization, not an insurer. It does not provide “professional liability insurance” to physicians. Moreover, CMPA protection and assistance cannot be considered “coverage” as this term commonly implies an insurance-type or contractual relationship. Yet, membership in the CMPA is expressly recognized in the Regulations as satisfying the requirement that physicians have adequate liability protection. As such, reference to "insurance" or "coverage" in subsections 40(1)(c) and 41(1)(c) of Bill 18 appear not to recognize the validity of CMPA membership pursuant to the Regulations. Although the Ministry added the term "coverage" to these subsections in Bill 18 in an attempt to respond to the CMPA's concerns, there appears to have been a misunderstanding as to the solution recommended by the CMPA.

The continued exclusive use of the terms "insurance" and "coverage" may not be adequately broad so as to include CMPA protection for physicians. Instead, sections 40 and 41 should be amended to reflect the same language that appears in the Regulations, with the exception that the word “protection” should be used instead of “coverage”. The objective is to use language that is not restrictive to "insurance". This can also easily be accomplished by referring generically to "professional liability protection" or by specifying membership in the Canadian Medical Protective Association as it currently included in Regulation 25/2003.

The risk to Manitoba physicians is that reference only to “insurance” and “coverage” in Bill 18 may be interpreted as not recognizing the validity of CMPA membership pursuant to the Regulations. Physicians practicing in the province, therefore, might be at risk of practicing in violation of the requirements of the Act if it is passed in its current form. The CMPA urges the Standing Committee to recommend to the Legislature that Bill 18 be amended to include the same language as appears currently in The Medical Act and the Regulations, which refers to “protection” in addition to “coverage” or “insurance”. In many other jurisdictions, this objective has also been accomplished by referring generically to “professional liability protection” or by specifying that membership in the Canadian Medical Protective Association (CMPA) is acceptable.

Ancillary Orders By Panel of Inquiry Committee & Authority of Council re: Contravention of Orders

Bill 18 would expand the orders that an inquiry committee may make to include "any ancillary order" in connection with the main order pursuant to subsection 126(3). Amongst other things, the inquiry committee may order a further or new investigation into "any matter" and may convene a panel to hear a complaint without an investigation.

The CMPA states that section 126(3) should be amended to include procedural guarantees in the circumstances of an ancillary order, including the right of the member to respond to the decision to conduct a further/new investigation or to convene a panel to hear a complaint without an investigation.

If passed, section 126(3) would significantly broaden the potential scope of investigation of the CPSM to include matters outside of the complaint that is before the panel. Although such ancillary orders can be appealed to the Court of Appeal, it is nevertheless important that the member who is the subject of such an order be afforded notice of the decision, full disclosure and an opportunity to make submissions. The CMPA is particularly concerned about the proposed new power to convene an inquiry panel to hear a complaint without a proper investigation. This would effectively deprive the member of the procedural benefits of an investigation, such as proper notice and an opportunity to respond before the complaints investigation committee.

Subsection 126(6) also suggests that Council would have the authority to cancel or suspend the member’s registration or certificate of practice, without receiving evidence or submissions on behalf of the member, if it has determined that an investigated member has contravened an order under subsection 126(1), which sets out the penalties that the inquiry committee may levy after a finding is made against the member. Subsection 126(6) should be deleted since it would be a violation of the principles of

natural justice for Council to impose such a serious penalty without affording the member a right to present evidence and make submissions as to whether the order has been breached. Although Council's decision to cancel or suspend a member's registration or certificate of practice may not be within the scope of "decisions" subject to appeal to the Court of Appeal (section 130 permits only appeals from a decision of a "panel"), such a decision would be subject to judicial review.

It is vitally important that the new Act generally provide members with the minimum elements of procedural fairness and natural justice, such as notice of any decisions, reasons, full disclosure and an opportunity to make submissions in response to an investigation or an allegation that an order of the inquiry committee has been breached. In the particular context of ancillary orders, members must be given an opportunity to respond to the panel's finding, including the appointment of a panel by the inquiry committee. Similarly, a member must have the same rights in responding to an alleged breach of an order that he/she has in responding to a complaint. Council must not be permitted to circumvent this process by making a unilateral determination under section 126. As it stands, the Bill would not require members to be granted these important procedural rights that are consistent with the College's duty to conduct their proceedings in accordance with principles of natural justice and procedural fairness. Legislating these obligations on the College will ensure that members' rights will be consistently protected.

Compellable Witness

The CMPA is particularly troubled by section 119 of Bill 18 that proposes to make "any person" a compellable witness before the inquiry committee (s.119(1)). Although the CMPA states otherwise, it is possible that "any person" could be interpreted broadly to include the member who is under investigation. If so, this provision would represent a dramatic change from the current provisions in The Medical Act that expressly protect a physician's right not to testify in his/her own defence at a College hearing.

Currently, subsection 59.2(1) of The Medical Act states:

Any person, other than the member whose conduct is the subject of the hearing, who in the opinion of the panel has knowledge of the complaint or matter being heard is a compellable witness in any proceeding before the panel.

Subsection 119(1) of Bill 18 should be amended to maintain the existing protections in The Medical Act, which expressly state that a member whose conduct is the subject of the hearing is not a compellable witness in any proceeding before the inquiry committee. The CMPA's concern in this regard is heightened by the fact that subsection 119(7) of Bill 18 would expose any witness who refuses to answer questions under oath before the panel may to civil contempt of court proceedings. A member under investigation must not be compelled or swayed by the threat of legal sanction into forgoing any of his/her fundamental procedural rights.

The CMPA respectfully submits that subsection 119(1) of Bill 18 should be deleted and replaced by the current language of subsection 59.2(1) of The Medical Act, which protects the fundamental right of the member under investigation to refuse to testify in his/her own defence.

Conclusion

The CMPA expresses its appreciation to the Standing Committee for the opportunity to comment on Bill 18. The CMPA's submissions are aimed at ensuring an equitable balancing between the rights of physicians and the protection of the public. While the above issues represent the most significant concerns arising from Bill 18 for CMPA member physicians in Manitoba, there are a number of other serious concerns outlined in detail in the enclosed copy of the CMPA's submissions to the Ministry in response to the initial draft legislation, which the CMPA respectfully requests be given consideration by the Standing Committee.

Yours very truly,

John E. Gray, MD, CCFP, FCFP Executive Director / CEO

C. Mr Rick Yarish Clerk, Standing Committee on Human Resources

Dr William S. Tucker, President -CMPA; Dr Lawrence Groves, Councillor -CMPA; Dr William Pope, Registrar-CPSM; Mr John Laplume, CEO – Doctors Manitoba

Encl. Letter to B. Millar (Manitoba Health), dated February 23, 2009

Ms. Barbara Millar
Senior Policy Analyst
Legislative Unit
Manitoba Health and Healthy Living
300 Carlton Street
Winnipeg MB R3B 3M9

Dear Ms Millar,

Re: Proposed Umbrella Health Profession Legislation

The Canadian Medical Protective Association ("CMPA") welcomes this opportunity to make submissions to Manitoba Health and Healthy Living (the "Ministry") on proposed umbrella legislation concerning the regulation and discipline of regulated health professionals in Manitoba as set out in The Health Professions Regulatory Reform Consultation Document, dated January 2009 (the "consultation document").

CMPA

As the principal provider of medico-legal assistance to Manitoba physicians, the CMPA can foresee the important ramifications that the proposed Regulated Health Professions Act ("RHPA" or the "Act") will have on Manitoba physicians. The CMPA has been actively involved in similar initiatives in other provinces aimed at reforming the legislative framework around the regulation of health professions. As such, the CMPA is uniquely positioned to offer the Ministry a broad perspective based on its national experience with the issues raised in the consultation document.

The CMPA is a not-for-profit **mutual** defence organization run **for and by** Canadian physicians. It is the principal provider of medico-legal assistance to Canadian physicians, including approximately 2,700 Manitoba physicians. The most obvious expression of the CMPA's assistance to its members is the provision of legal representation, including the payment of legal costs, judgments or settlements to compensate patients with meritorious claims. It is equally significant that the CMPA provides broader advisory services to its members on a multitude of medico-legal issues, including advising on matters before regulatory bodies. Consequently, any legislative changes to the regulation of physicians and other health professionals will have important implications for the CMPA and its Manitoba members.

Summary of CMPA Recommendations

The CMPA seeks confirmation as to whether the complaints process proposed in the draft legislation for health profession regulatory authorities (i.e. Colleges) is intended to apply to the College of Physicians and Surgeons of Manitoba ("CPSM"). If not, the CMPA looks forward to the opportunity to offer its comments on any additional parts of the proposed RHPA applicable to physicians.

Assuming that the uniform legislative framework proposed in the consultation document, including the complaints, investigation and inquiry procedure, is intended to be applicable to all health professions in Manitoba, including physicians, the following is a summary of the CMPA's comments that will be discussed in further detail below:

- Sections 41 and 42 should be amended to recognize CMPA membership as an acceptable means of "professional liability protection". The term currently proposed, "professional liability insurance", does not incorporate physicians' CMPA membership, which is not "insurance".
- Amendments to the public content of the College register or website should not be left to the College by-laws or Regulations. Such changes should only be made through amendments to the legislation. In this regard, subsection 29(f) of the RHPA, allowing the information included on the College's register to be expanded by Regulation, should be deleted. In addition, subsection 135(1) should be amended to specify within the body of the legislation the information that will be publicly available on the College website.
- The College should not be permitted to publish the circumstances of a member's voluntary surrender of his/her registration as proposed in subsection 96(3) or unresolved malpractice "claims" pursuant to subsection 129(3)(a)(viii). These sections should be deleted.
- The College should be restricted from publishing any information about a member, including following interim action against the physician pursuant to section 124, until the allegations have been proven and the member has been afforded due process.
- Section 103, authorizing the College to report possible criminal activity by a member, should be amended to provide appropriate safeguards to limit the information that can be provided to the

police and the uses to which evidence collected in the course of a College investigation can be used for this purpose.

- Section 83 should require the College to provide the member who is the subject of the complaint with notice of the complaint and a copy of the complaint submitted by the complainant. Subsection 119(3) should also be amended to clarify that the registrar must provide a copy of the inquiry committee's decision and reasons to the investigated member and the complainant.

- Members should be afforded an expedited hearing before any interim suspension is ordered pursuant to section 101. In addition, an interim suspension should not be ordered absent reasonable and probable grounds to believe that the member poses a serious risk to patient safety and that urgent intervention is required.

- The member should be entitled to an opportunity to respond to the decision of the inquiry committee making an ancillary order pursuant to section 117, particularly when a new panel is convened to hear a complaint without an investigation.

- Subsection 121(1) of the RHPA should be amended so as not to limit the scope of the member's right of appeal to only questions of law or jurisdiction.

- Subsection 109(1) the RHPA should be amended to continue to provide (as is currently stated in The Medical Act) that a member whose conduct is the subject of the hearing is not a compellable witness in any proceeding before the inquiry committee.

- Section 116 concerning "deemed professional misconduct" for discipline action in other jurisdictions should be deleted. Subsection 117(2) permitting the inquiry committee to consider prior decisions should be clarified to provide that the committee may only do so where the allegations have been substantiated/proven in the other jurisdiction(s).

- The College's authority to inspect and observe a physician's practice as proposed in section 90 should be subject to reasonable limits. The authority to require any person to answer questions in subsection 90(1)(f) must be amended to reconcile the potential conflict of such a provision with the physician's duty of confidentiality to protect the personal health information of their patients.

- The RHPA must be amended to provide for appropriate procedural guarantees to protect any information gathered during mediation or other settlement processes from being disclosed to the investigator or any other committee of the College (see, for example, sections 83, 86, 93 and 94).

- Section 105(1) should require the appointment of a retired judge or other respected senior member of the legal profession to each inquiry committee.

- The Act should include a means to enforce time limits proposed in section 106 concerning when the inquiry committee must commence its hearing and in subsection 119(1) that entitles the member and the complainant to written notice and reasons within 90 days after a hearing.

- Assuming the RHPA will repeal The Medical Act, it should incorporate the limitation period currently set out in section 61 of The Medical Act.

Application to Manitoba Physicians

It is unclear from the information available at this time whether some or all of the provisions of the proposed RHPA are intended to apply to physicians, who are currently governed by The Medical Act. The consultation document acknowledges that the proposed legislation is an incomplete draft. As such, it appears to leave the door open for additional profession-specific provisions.

The CMPA welcomes any further information as to whether the Ministry may be considering separate parts or sections for the RHPA applicable to individual health professions, such as physicians. In the event that any additional provisions are being considered, the CMPA looks forward to the opportunity to comment on same.

The CMPA assumes for the purpose of the following discussion that all of the provisions proposed in the RHPA would apply to the CPSM and to physicians in Manitoba. In any event, the CMPA hopes that its comments may be of some broad assistance to the Ministry in considering an appropriate legislative model for physician regulation in Manitoba.

Mandatory Liability Protection

Sections 41 and 42 address the process by which the Colleges would certify members to practice. Subsections 41(1)(c) and 42(1)(c) require "regulated members" and "regulated associate members" to "provide evidence of having the amount and type of professional liability insurance, if any, required by the college's regulations."

The CMPA has consistently recommended that health professions legislation require members to have adequate professional liability insurance or membership in a professional liability protection association as a condition of licensure. The trend in the health care sector toward collaborative practices necessitates that professional liability insurance or membership in a professional liability protection association should be a requirement for licensure with a College. Such protection is also essential to better protect patients by ensuring that they receive appropriate compensation in the event of negligence.

Subsection 19(g) of The Medical Act currently authorizes CPSM Council to make regulations;

(g) respecting professional liability coverage, or other liability protection, for members, associate members and medical corporations;

Manitoba Regulation 25/2003 concerning the Registration of Medical Practitioners states:

13(1) Every licensed member must possess and maintain professional liability coverage that extends to all areas of the member's practice, through either or both of:

a) membership in the Canadian Medical Protective Association;

b) a policy of professional liability insurance issued by a company licensed to carry on business in the province, that provides coverage of at least $10,000,000.

As stated above, the CMPA is a mutual-defence organization, not an insurer. Yet, membership in the CMPA is expressly recognized in the Regulations as satisfying the requirement that physicians have adequate liability protection. As such, reference to "insurance" in subsections 41(1)(c) and 42(1)(c) in the RHPA does not recognize the validity of CMPA membership pursuant to the Regulations.

Sections 41 and 42 of the RHPA should be amended to include the same language that appears in the Regulations, with the exception that the word "protection" should be used instead of "coverage". The objective is to use language which is not restrictive to "insurance". This can also easily be accomplished by referring generically to "professional liability protection" or by specifying membership in the Canadian Medical Protective Association.

The CMPA recommends that sections 41 and 42 of the RI-IPA be amended to require as a condition of certification that members have adequate professional liability insurance or membership in a professional liability protection association as stated currently in Regulation 25/2003.

Disclosure of Information

(i) Website and Register

The RHPA proposes to designate certain information as being public, meaning that it will be available for public inspection through either the College register or its website. The CMPA understands that the Ministry sees this as part of the Colleges' mandate to protect the public interest. Without proper safeguards, however, the provisions as currently worded in the RHPA risk providing the College with unfettered discretion to expand the information that is available to the public. In specific cases, this unnecessarily risks exposing members to harm by publicly disclosing potentially prejudicial information concerning unfounded allegations, settlements and other matters.

Although the RHPA would require the websites for each College to include information intended to improve public disclosure (s.135), the specific information that will be posted on the website is to be decided by Regulation. Section 29 sets out the general information that must be included on the College register, but also leaves the door open for additional information to be specified by Regulation.

It is unclear from these provisions whether these Regulations will require Cabinet approval. Any decision to amend the content of the public register or the College website could have extremely significant implications for physicians. Consequently, changes to the register or website should only be permitted by way of legislation, with full opportunity for dialogue with and comment from stakeholders.

The CMPA is concerned at the prospect of the CPSM being provided broad discretion to expand the information it posts on its website and register concerning physicians without either Ministerial

oversight or stakeholder consultation. Without clear legislative direction, the College could conceivably expand the information that it will disclose to the public concerning physicians simply by approving a bylaw. Much of this information is often sensitive and subject to misinterpretation by the public.

The CMPA recognizes that one of the procedural changes being proposed in the consultation document is that the Colleges must consult with their membership on proposed Regulations or by-laws. Although membership approval would not always be required, the CMPA believes that this generally represents a significant step forward in improving communications and consultations by the Colleges.

Nevertheless, in the context of possible amendments to the public content of the register and/or website, the CMPA submits that this should not be left to College, even with the proposed improvements in member consultation. The CMPA recommends that the proposed subsection 29(1) of the RHPA be deleted and that subsection 135(1) be amended to specify the information that will be publicly available on the website.

(ii) Physician Profiling

The RHPA proposes that the complaints investigation committee be permitted to publish the name of a member who has voluntarily surrendered his/her registration or certificate of practice (s.96(3)). The published information may include the circumstances that led to the voluntary surrender. Currently, The Medical Act permits the committee to do so only where the member has been censured.

The fact that the College may publish the circumstances of a voluntary surrender may have a chilling effect on physicians who would have otherwise considered this as a means of settling a College complaint in the interest of avoiding subjecting the complainant, the College and the member to a public hearing.

In addition, subsection 129(3)(a) would authorize Council (with Cabinet approval) to make Regulations concerning practitioner profiles, which would be publicly available. Amongst the information that may be included in the profile are:

(viii) a description of any malpractice court judgments, and any other malpractice claims, as specified in the regulations;

(ix) any other information the regulations may specify.

It is unclear from the use of the word "claims" in subsection 129(3)(a)(viii) whether the information being proposed would include legal proceedings that have not yet been adjudicated or substantiated.

Sections 129 and 96 may allow the College to publicly disclose information that could potentially be prejudicial to physicians. The CMPA consistently takes the position that information concerning matters in which there has been no finding adverse to the physician is of little probative value and potentially highly prejudicial to physicians. As will be discussed further below, the disclosure of information about unproven allegations to other licensing authorities, hospitals or the public could have negative consequences for the physician. Amongst other things, this information is often mere speculation concerning potentially unfounded complaints, frivolous actions or matters concerning which the physician will be ultimately exonerated.

Some receiving this information might wrongly assume that because an allegation of wrongdoing originates from the College it has been proven to be true. These notations have the ability to be highly prejudicial to physicians. Conversely, little probative value is typically gained in making such inflammatory information public. The CMPA recommends that the proposed subsections 96(3) and 129(3)(a)(viii) of the RHPA be deleted. In the alternative, it is sufficient that the College be permitted to publish only that the member has voluntarily surrendered his/her registration or certificate.

(ii) Reporting to Hospitals or Other Colleges

The RHPA would require professionals to report another member who is suffering from a physical or mental condition or disorder that affects his/her ability to practise. In addition, "employers" would also be required to report misconduct or incapacity. The Act would also contain a new provision requiring the College to provide notice to "employers" when it suspends, cancels or otherwise restricts a member's registration or certificate of practice (s.124). Any hospitals at which the member is part of the medical or professional staff are included amongst the bodies to which the College would report in these circumstances. The College may also give notice to the minister responsible for health care services payments and to any "external regulatory bodies in other provinces or territories."

Somewhat paradoxically, section 114 of the RHPA would appear to provide safeguards for members by

prohibiting any person from publishing anything that may identify the member under investigation, even if the hearing before the inquiry committee is otherwise public. Information such as the member's name and location of practice could not be published until a finding under section 115(2) has been made by the panel.

It is unclear whether section 114 would prevent the College from disclosing to a hospital or other College that it has taken interim action to suspend a member pursuant to section 101. For example, would section 114 prevent the College from disclosing to a hospital that it has, on an interim basis, suspended a member of its medical staff? Assuming the provisions in the RHPA concerning interim suspensions remain unchanged (as will be discussed further below), the CMPA's concern is that the College may conceivably restrict a member's registration (and report to a hospital or other College) prior to the member being given an opportunity to respond.

The CMPA respectfully requests clarification as to the potential interaction between sections 101, 114, and 124 of the RHPA. Specifically, would the College be permitted under section 124 to report an interim suspension ordered pursuant to section 101, notwithstanding the protections offered by section 114 concerning ongoing investigations? In any event, as discussed above such authority must be exercised judiciously given the potential implications on a physician's practice. The College should be restricted from publishing any information about the member in circumstances where the allegations have not been proven or the member has not been afforded due process.

(iv) Reporting Possible Criminal Activity

Both the current Medical Act and the proposed RHPA contain provisions allowing the College to disclose certain information to law enforcement agencies about "possible criminal activity by a member" (s.103). While this provision may be perceived to be a re-statement of the College's unwritten practice and general ethical obligation to protect the public, the CMPA is concerned by the lack of any reasonable parameters on this authority in section 103.

The CMPA does not dispute that if the College is in possession of information that a member engaged or is engaging in criminal activity, from a public policy perspective it should bring such information to the attention of the appropriate authorities in the general public interest. That being said, section 103 lacks any parameters or guidance as to when such a report should be made. For example, it does not specifically require that the information of "possible" criminal activity meet the basic threshold of reasonable grounds. The CMPA recommends that section 103 should be amended to permit the College to make such a report only if the complaints investigation committee believes, on reasonable grounds, that the member has committed or is committing criminal activity. Similar to a recent policy approved in by the College of Physicians and Surgeons of Nova Scotia, the RHPA should also require the committee to consider issues such as the "sufficiency of the information" and the "stage of the investigation or the discipline hearing" when deciding whether to report.

Section 103 permits the complaints investigation committee to disclose "information" obtained during its investigation. It does not specify whether "information" includes evidence, such as documentation or witness statements. The Act should expressly prohibit the College from disclosing to the police specific documents, statements or other evidence obtained in the course of its investigations. While the College may have an ethical duty to report suspected criminal activity to the police, this should not extend to acting as an agent for the police in providing evidence to support the allegation. The information the committee can provide to the authorities without a warrant or court order should be expressly limited to the minimum information necessary to satisfy the intended purpose of notifying the police of the suspected criminal activity. In other words, the College should not be permitted (absent patient consent, a warrant or a court order) to provide any additional information or evidence that the police would otherwise be responsible for obtaining in the course of its own investigation into the suspected criminal activity.

The CMPA submits that section 103 should be amended to impose reasonable limits on the authority of the College to report suspected criminal activity to law enforcement agencies. Such amendments may include requiring the College to have "reasonable grounds" to believe that the member engaged or is engaging in criminal activity. The Act should also prohibit the College from disclosing any further information than is necessary to alert the authorities to the suspected activity.

Complaints, Investigation and Inquiry Process

Part 8 of the RHPA sets out the process by which the Colleges will address complaints and member discipline. As discussed above, the CMPA seeks confirmation that these provisions are intended to apply to physicians and the CPSM. In the interim, the following are the CMPA's comments on the current proposal, the broad principles underlying which may be of some assistance to the Ministry in drafting any additional provisions that it may be considering.

(i) Notice to Member

The RHPA should be amended to require the College to provide the member with a copy of the complaint that the complainant submits under section 82 of the RHPA. It currently does not require the registrar to notify a member who is the subject of a complaint when it is received or to provide him/her with a copy of the complaint. The first notice the member is entitled to receive is when the complaints investigation committee completes its investigation.

Subsection 83(1) of the RHPA would require the registrar to notify the complainant of the action taken with respect to his/her complaint 30 days after receipt. Similarly, subsection 85(1) would require notice to be given to the complainant when his/her complaint is dismissed. The entitlement to such information does not extend to members who are the subject of the complaint.

With respect to the investigations process, section 88 would require the registrar to notify the complainant when an investigator has been appointed. The member under investigation is not entitled to notice that an investigator has been appointed. While he/she may receive "reasonable particulars of the complaint," it is only if there would be no significant harm to the investigation. Otherwise, the registrar is only required to provide this information to the member "before the investigation is completed" (5.88(2)).

It is the CMPA's experience that under the current complaints process, physicians are provided with notice or a copy of the complaint to the College, except in the case of a registrar's referral. Conversely, it is our understanding that complainants are routinely provided with relevant documents. This can present a number of difficulties for the physician and raises procedural fairness concerns. For example, it is not uncommon for the nature of the allegations to change (either slightly or significantly) as the matter proceeds. If the physician does not receive copies of the actual allegations made in the complaint, the physician may be unable to respond effectively. It is generally accepted that an important element of procedural fairness is that the individual should know with some precision the case he/she has to meet. It is the CMPA's submission that it is unfair to members not to provide them with a copy of the complaint against them.

The CMPA recommends that subsection 83(1) of the RHPA be amended to require the College to provide a member who is the subject of the complaint with notice of the complaint and a copy of the complaint submitted under section 82 of the RHPA. In addition, subsection 119(3) requires the registrar to provide a copy of the "decision" to the investigated member and the complainant. The CMPA recommends that this section be amended to clarify that this is intended to include the written reasons of the panel, in addition to the decision itself.

(ii) Interim Suspension

Section 101 of the RHPA would authorize the complaints investigation committee to direct the registrar to suspend a member pending the outcome of the committee's investigation where it is necessary to protect the public from "exposure to serious risk". The registrar must provide written notice of the suspension to the member and, where applicable, his/her employer or any other person specified in the Regulations. The member has the right to appeal the order to Council, which must hold a hearing within 30 days of receiving notice of the appeal. The member can also apply to the court for a stay of the interim suspension order.

Although the suspension powers proposed in the RHPA are largely reflective of provisions currently set out in The Medical Act, the CMPA is concerned that these provisions represent an unjustifiable incursion on physicians' procedural rights by denying them an opportunity to make submissions before the order takes effect. Specifically, the member would only be provided with a right of appeal after the order is made and not an opportunity to make submissions to the committee while the order is being considered. While it is encouraging that Council must hear any appeal within 30 days, the period under the current legislation for the executive committee to hold a hearing is 14 days. In any event, the CMPA submits that this right of appeal is not sufficient to remedy the fundamental procedural fairness problems with these provisions.

The CMPA is also concerned that the RHPA does not appear to require that reasons be given to a member if Council confirms an order under section 101. The CMPA submits that providing members with reasons for this extraordinary action is another example of the important safeguards that must be in place if such a provision is to be included in the RHPA.

The CMPA submits that the RHPA should be amended to provide members with an expedited hearing before any interim suspension is ordered. In addition, further safeguards are necessary to protect physicians' procedural rights in these circumstances. While recognizing the College's duty to protect the public, such an order should only be made in situations where there are reasonable and probable grounds to believe that the member poses a serious risk to patient safety and urgent intervention is required. In addition, members must be given reasons for any order made under section 101.

(iii) Ancillary Orders

The orders that an inquiry committee may make would be expanded under the RHPA to include "any ancillary order" in connection with the main order. Amongst other things, the committee may order a further or new investigation into "any matter" and may convene a panel to hear a complaint without an investigation (s.117(3)). Subsection 117(6) suggests that Council have the authority to cancel or suspend the member's registration or certificate of practice, without receiving evidence or submissions on behalf of the member, if it has determined that an investigated member has contravened an order as to penalty.

It is arguably a violation of the principles of natural justice to permit the Council to impose such serious penalties without affording the member a right to present evidence and make submissions as to whether the order has been breached. It is recommended that subsection 117(6) of the RHPA be deleted

If passed, these provisions would significantly broaden the Colleges' potential scope of investigation to include matters outside of the complaint which is before the panel. Although such ancillary orders can be appealed to the Court of Appeal, it is nevertheless important that the member who is the subject of such an order be afforded notice of the decision, full disclosure and an opportunity to make submissions. The CMPA is particularly concerned about the committee's proposed new power to convene an inquiry panel to hear a complaint without a proper investigation. This effectively deprives the member of the procedural benefits of an investigation, such as proper notice and an opportunity to respond before the complaints investigation committee.

It is vitally important that the RHPA generally provide members with the minimum elements of procedural fairness and natural justice, such as notice of any decisions, reasons, full disclosure and an opportunity to make submissions in response to an investigation. In the particular context of ancillary orders, members must be given an opportunity to respond to respond to the panel's finding, including the appointment of a panel by the inquiry committee. As it stands, the RHPA does not require that members will be granted these important procedural rights that are consistent with the College's duty to conduct their proceedings in accordance with principles of natural justice and procedural fairness. Legislating these obligations on the College will ensure that members' rights will be consistently protected.

The CMPA recommends that section 117 of the RHPA be amended to include procedural guarantees in the circumstances of an ancillary order, including the right of the member to respond to the decision to conduct a further/new investigation or to convene a panel to hear a complaint without an investigation.

(iv) Appeal of Decision of Inquiry Committee

Section 59.10 of The Medical Act currently states that only a member has the right to appeal a decision of an inquiry committee. Subsection 121(1) of the RHPA proposes that the right of appeal be extended to include the College. However, the grounds of any appeal by either the College or the member would be narrowed to only questions of law or jurisdiction.

The Manitoba Court of Appeal has clearly stated that it will defer to findings made by a tribunal with specialized knowledge, such as the CPSM, and will only intervene in clear cases. It is therefore unclear why the scope of the member's right of appeal is being restricted by statute. Given the potential significance of decisions made of the inquiry panel on the member's ability to practice his/her profession, it is recommended that the scope of the member's right of appeal not be restricted and section 121(1) of the RHPA be amended accordingly.

The CMPA recommends that subsection 121(1) of the RHPA be amended so as not to limit the scope of

the member's right of appeal to only questions of law or jurisdiction.

(v) Compellable Witness

A particularly troubling new provision proposed for the RHPA is that members and complainants would both be considered compellable witnesses before the inquiry committee (s.109(1)). Any witness who refuses to answer questions under oath before the panel may be subject to civil contempt of court proceedings (5.109(7)).

Currently, subsection 59.2(1) of The Medical Act states:

Any person, other than the member whose conduct is the subject of the hearing, who in the opinion of the panel has knowledge of the complaint or matter being heard is a compellable witness in any proceeding before the panel.

If passed in its current form, the RHPA would effectively remove a physician's existing right not to testify in his/her own defence at a College hearing, which is an important fundamental right of any defendant or respondent.

The CMPA respectfully submits that subsection 109(1) of the RHPA should be deleted. In its place, language should be inserted such as that which is currently contained in subsection 59.2(1) of The Medical Act.

(vi) Prior Decisions

The RHPA would permit an inquiry committee to be advised of any censure or order previously issued to the investigated member and the circumstances under which it was issued" (s. 117(2)).

Although the committee is only permitted to consider prior decisions, it is unclear from the language of the draft legislation whether the committee may consider complaints where the allegations were unsubstantiated. For example, if the term "order" as used in this section includes an order by the registrar to dismiss the complaint at an early stage, the member may be unfairly prejudiced by details concerning the circumstances of the complaint that was ultimately without basis or to which the member did not have the opportunity to respond at the time.

In addition, subsection 47(2) provides that Council may cancel a member's certificate of registration or practice (or both) if he/she has been convicted of an offence relevant to his/her "suitability to practise." Prior to taking such action, Council must first notify the member of the intended action and provide him/her an opportunity to make submissions. The RHPA would also deem a member to be guilty of professional misconduct who has been convicted of an indictable criminal offence or who has had his/her registration suspended, restricted or revoked by an "external regulatory body" (s.116). The member has no opportunity to make submissions with respect to the deemed finding of professional misconduct, only with respect to the penalty to be imposed pursuant to section 117.

The concept of assumed "guilt" based on a decision made by another tribunal (without any further investigation concerning the circumstances or the process by which the member was disciplined) is troubling from a legal standpoint. At the very least, the member should be entitled to an oral hearing before the committee prior to such a significant and potentially career-threatening order being made. By contrast, subsection 45(1.1) of The Medical Act provides that such circumstances may result in a referral of the matter to the investigation committee which affords the member the due process lacking in the RHPA.

The CMPA recommends that section 116 concerning deemed professional misconduct be deleted and that subsection 117(2) be clarified to stipulate that the committee may only consider prior decisions in which the allegations have been substantiated/proven.

(vii) Powers of Investigator

Subsection 90(1) of the RHPA would expand the powers of College investigators to include, amongst other things, the authority to:

a) enter and inspect any premises or place where the investigated member practises or had practised the regulated health profession;

b) inspect, observe or audit the member's practice;

c) examine any equipment or materials used by the investigated member;

d) require the investigated member to respond to the complaint in writing;

e) require any person to answer any relevant questions, which may include directing the person to answer the questions under oath;

f) require any person to give to the investigator any document, substance or thing relevant to the

investigation that the person possesses or that is under his or her control.

The failure of any member or former member to answer questions, produce documents or grant an inspector access to premises under the member's control will be deemed to be professional misconduct (s.91(4)).

The CMPA is concerned that subsection 90(1) as a whole would provide the CPSM with excessively broad authority to investigate a physician's practice without necessarily requiring reasonable grounds. Specifically, the Act would appear to grant the College with unlimited authority to indiscriminately and seemingly without justification directly observe a physician in his/her practice in potentially any and all aspects of his/her practice, including while performing procedures. The College's inspection authority would also appear to extend beyond the conduct of the member to include the inspection of any equipment or materials used in his/her practice. There are no limitations currently proposed in the Act addressing the circumstances in which such a potentially intrusive inspection could be ordered or how often it can occur.

Similar inspection powers in other jurisdictions are defined or limited by the language of the Act. The proposed provisions of the RHPA in Manitoba are by comparison less circumscribed. For example, subsection 95(h) of the Regulated Health Professions Art in Ontario authorizes the inspection of only specific components of a physician's practice, such as the premises, equipment, books, accounts, reports and records. In addition, the CPSO's investigation authority under section 75 of its RHPA is limited to circumstances where, amongst other things, it is believed on reasonable and probable grounds that the physician has committed an act of professional misconduct or is incompetent. By contrast, section 90 of the RHPA in Manitoba does not appear to provide any similar reasonable constraints on the circumstances in which this potentially onerous inspection authority can be exercised.

Such broad inspection authority can have a potentially negative effect on a physician's practice. For example, many physicians in private practice perform several different types of procedures. Under the proposed inspection authority, the College may arbitrarily determine that it will conduct repeated visits to the clinic to inspect the different areas of the physician's practice. Unlike the examination of records and other office documents, a direct observation inspection would necessarily have to be carried out in the presence of patients in the vast majority of cases. It is not difficult to imagine that repeat visits from a College inspector to observe the various procedures and areas of the physician's practice could be disruptive to the operation of the clinic and disconcerting to many patients.

Amongst other questions arising from this proposal is whether patient consent would be required before an inspector is permitted to observe a procedure. In addition, would the inspector be permitted to have any contact or to otherwise communicate with the patient before, during or after such an inspection?

The authority to inspect equipment and materials used in a member's practice raises questions about whether the College is properly qualified to assess the appropriateness or suitability of equipment or materials, particularly new medical devices. If the College must rely on experts to assess such equipment, who will bear this cost? Is the regulation and approval of medical devices a function better left to other regulatory bodies, such as Health Canada?

The proposal that College inspectors be provided with the authority to require any person to answer questions or to provide documents is also a significant concern to the CMPA and its Manitoba members. It is conceivable that such a provision could be used in some cases to require physicians (including those outside of Manitoba) to disclose the personal health information of their patients. Although the legislative provisions vary between provinces, health information custodians are generally permitted to disclose such information only with the patient's consent or where authorized/required by law (such as a court order).

Subsections 90(1)(e) and (f) of the RHPA as currently worded would authorize the investigator to "require any person to answer any relevant questions". It would not require or obligate that person to answer the questions or to disclose the requested documents. As such, some privacy legislation and/or the physician's general duty to maintain patient confidentiality may prevent some physicians from complying with the investigator's request without an order directing him/her to disclose the information.

While the CMPA does not dispute the College's inherent authority to inspect or investigate a physician's practice, it is reasonable to expect that there should be some reasonable limits on this authority set out in the legislation that defines its

parameters. At a minimum, section 90 should be modified to limit the College's discretion and authority to directly observe a physician in his/her practice.

The CMPA recommends that section 90 be amended to clarify the scope of the College's proposed inspection authority to address issues such as how often the College may inspect the premises, what circumstances would give rise to a direct inspection of a procedure (e.g. reasonable and probable grounds to believe that a procedure is exposing patients to an unacceptable risk of harm), and what will happen if the patient refuses to consent to the inspector being present. In addition, subsection 90(1)(f) should be modified to recognize that the Act does not override privacy legislation and physicians' confidentiality obligations towards their patient that may justifiably prevent some health information custodians from disclosing this information to an investigator.

(viii) Alternative Dispute Resolution

The RHPA places a renewed emphasis on the informal resolution of complaints. For example, the complaints investigation committee may refer the complaint to mediation, but only on consent of both parties (s.93(1)(c)). The committee would also have the express authority to attempt to resolve complaints, where appropriate (s. 86). In addition, the registrar would be permitted to encourage "communication" between the complainant and the member in an attempt to resolve the complaint (s. 83(2)).

Although the CMPA is generally very supportive of any reasonable ADR process in the context of College complaints, proper procedural safeguards must be included in the legislation to protect such "without prejudice" settlement discussions from inappropriate use by the College or the complainant in other settings. Section 94 states that if mediation is unsuccessful, the matter is referred back to the complaints investigation committee for further consideration. The draft legislation does not, however, provide any guidance as to who would conduct the mediation and what use, if any, the College or another party can make of the information disclosed in the course of such settlement discussions.

The CMPA submits that the RHPA should expressly provide appropriate protections for any information gathered during the mediation process from being disclosed to the investigator, any other committee of the College or any subsequent complaint or legal action. Section 93 should be amended to state, "Despite this or any other Act, all communications at an alternative dispute resolution process and the facilitator's notes and records shall remain confidential and be deemed to have been made without prejudice to the parties in any proceeding whatsoever". The CMPA further recommends that this provision be applicable to other "without prejudice" discussions, such as those contemplated in subsection 83(2) and section 86 of the RHPA.

(ix) Legal Expertise on Inquiry Panel

Subsection 105(1) addressed the composition of the inquiry committee. The CMPA submits that the College, complainants and members would all benefit from an amendment to this section that would require one member of an inquiry committee panel to be someone with legal expertise (e.g. a lawyer, retired judge, etc.).

Panel members at this stage of a College investigation are typically unfamiliar with the legal principles that must be applied to determine whether certain evidence is to be admitted or rejected. In the event that such evidence is not admitted, panel members will have heard and considered evidence adverse to the individual before them, but which is inadmissible. Panel members are typically not trained or experienced in excluding from their consideration matters that may not form part of their decision. In addition, the panel may benefit from the legal expertise of that one panel member in the preparation of reasons and the resolution of other procedural issues that might arise, such as third party record applications and severance motions.

The CMPA recommends that subsection 105(1) of the RHPA be amended to provide for the appointment of a retired judge or other respected senior member of the legal profession to each inquiry committee panel who would, in the absence of the other panel members, hear and determine those evidentiary and procedural issues typically dealt with by a trial judge in the absence of the jury.

(x) Timely Disposal

The RI-IPA proposes to extend the time during which the inquiry committee would be required to hold a hearing into a complaint. The committee currently must commence a hearing within 60 days following referral from the complaints investigation committee. The RHPA would extend that period to 120 days. In addition, the period for the registrar to provide written notice of the hearing would be

extended from at least 21 days before that start of the hearing to at least 30 days (5.106).

The RHPA also contains some important new provisions on this issue not currently included in The Medical Act. Specifically, the committee would be required to commence a hearing within this time, subject only to the consent of the member. Moreover, the committee must deliver its written decision (including findings, order and reasons) within 90 days after the hearing is concluded (s.119(1)). The current Act does not provide any timeline for the delivery of the panel's decision.

Although the CMPA does not have any significant concerns with the increase in the time before which the committee is required to hold a hearing (based on the additional procedural guarantees provided elsewhere in the Act), the RHPA is silent on the remedies afforded to the parties in the event that the committee does not adhere to the time limits. The Act should provide at least an appeal route that the parties may consider pursuing if the committee does not hold a hearing or deliver reasons within the specified time.

The CMPA seeks additional information from the Ministry on how these time limits will be enforced under the new Act. Amongst other things, the RHPA should specify the recourse available to the parties if the committee fails to commence a hearing or to deliver its decision within the specified time. In addition, the Act should require that the member and complainant be provided with written notice and reasons for any delay that may occur in meeting any of the timelines established under the Act.

(xi) Disclosure of Documents

The CMPA supports proposed provisions in section 110 of the RHPA aimed at improving procedural fairness for all parties involved in the complaints process. The Medical Act currently requires that members be given access to written or documentary evidence the day before the hearing. In the case of expert evidence, the time period for disclosure is not stated in the Act. Subsection 110(1) requires at least 14 days notice for documentary evidence, expert testimony (including name and qualifications of the expert, a copy of any written reports or a 'will-say" statement), and the name and "will-say" statement from any other witnesses. In this regard, the RHPA would significantly improve members' rights to disclosure in advance of a hearing.

(xii) Right to be Heard

The CMPA has consistently argued that physicians must be afforded with certain minimum procedural protections that would at least require the College to provide the member with an opportunity to respond to the complaint and, in some circumstances, to have the option of an oral hearing. Subject to the exceptions discussed earlier, the current draft of the RHPA appears to provide most of these minimum protections after the matter is referred to the complaints investigation committee.

Although the CMPA would have preferred that the legislation recognize the member's right to an oral hearing in these circumstances, the provisions proposed in the RHPA allowing for written submissions are a significant improvement over those currently contained in The Medical Act. For example, although a hearing is not required before the complaints investigation committee or on appeal of a decision of the committee, both the member and the complainant must be provided an opportunity to make written submissions to the committee (ss. 85(5), 93(2) and 100(3)).

Limitation Period

Section 61 of The Medical Act currently includes the following limitation period applicable to medical malpractice actions in Manitoba:

No member or medical corporation is liable in any action for negligence or malpractice by reason of professional services requested or rendered unless the action is commenced within two years from the date when, in the matter complained of, those professional services terminated.

The current draft of the RHPA contains no provisions respecting limitation periods for legal proceedings against health care professions. There has been significant judicial interpretation of section 61 of The Medical Act to date. This has resulted in greater clarity with respect to the time period within which an action must be brought against a physician. The certainty afforded by the language of section 61 benefits all stakeholders by preventing unnecessary litigation of stale claims while preserving the ability of parties to apply to the court for an extension of time to bring an action where the claim was not discoverable within the time prescribed.

The CMPA submits that a limitation period similar to section 61 of The Medical Act should be incorporated into the RHPA applicable to medical malpractice actions.

Conclusion

The CMPA wishes to express its gratitude to the Ministry for this opportunity to offer its submissions on the consultation document on proposed new health professions legislation in Manitoba. We appreciate the efforts the Ministry is taking to consult with interested stakeholders and look forward to continuing to work with the Ministry on this initiative.

The CMPA's submissions are aimed at ensuring an equitable balancing of the rights of physicians and the protection of the public. We sincerely hope that the Ministry will seriously consider the concerns raised by the CMPA in either amending existing provisions of the draft RHPA or in proposing new provisions applicable specifically to physicians. We look forward to being provided with an opportunity to comment on any additional draft legislation in this regard.

Yours very truly,

John E. Gray, MD, CCFP, FCFP
Executive Director / CEO
JEG/Ig
C: Dr William S. Tucker, President – CMPA
Dr William Pope, Registrar – CPSM
Mr John Laplume, CEO – Doctors Manitoba

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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

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