Fifth Session - Thirty-Sixth Legislature

of the

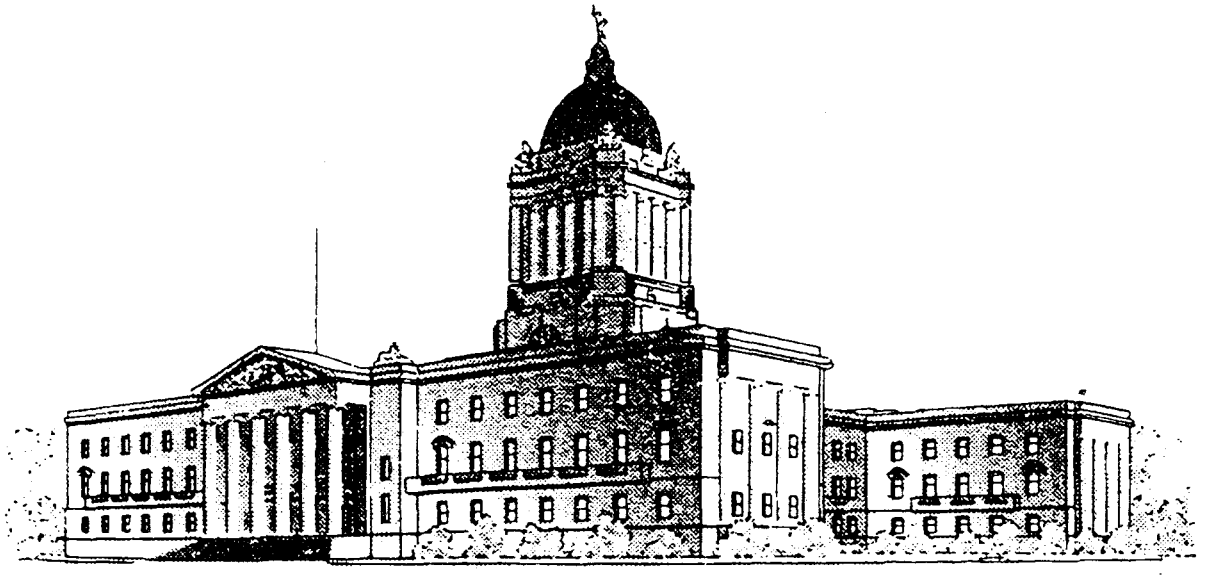
Legislative Assembly of Manitoba

Standing Committee

on

Industrial Relations

Chairperson
Mr. Peter Dyck
Constituency of Pembina



Vol. XLIX No. 1 - 7 p.m., Wednesday, July 7, 1999

ISSN 0713-9608

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Thirty-Sixth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON INDUSTRIAL RELATIONS

Wednesday, July 7, 1999

TIME – 7 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. Peter Dyck (Pembina)

VICE-CHAIRPERSON – Mr. Edward Helwer (Gimli)

ATTENDANCE - 9 – QUORUM - 6

Members of the Committee present:

Hon. Messrs. Derkach, McCrae, Radcliffe, Reimer, Stefanson

Messrs. Chomiak, Dyck, Helwer, Jennissen

APPEARING:

Mr. Gary Kowalski, MLA for The Maples
Mr. Kevin Lamoureux, MLA for Inkster

WITNESSES:

Bill 26–The Physiotherapists Act

Ms. Gloria Gallant, Private Citizen
Mr. Roland Lavallee, Private Citizen
Mr. Terry Woodard, Private Citizen
Dr. Anthony Wright, Physiotherapy, University of Manitoba
Dr. Greg Stewart, Manitoba Chiropractors' Association
Dr. Ken Brown, College of Physicians and Surgeons
Ms. Susan Morrow, Canadian Physiotherapy Association
Mr. Kelly Robert Milan, Private Citizen
Mr. Marc Arbez, Private Citizen
Mr. Murray MacHutchon, Private Citizen
Mr. Evelyn Lightly, Private Citizen
Ms. Brenda McKechnie, Association of Physiotherapists of Manitoba
Mr. Dennis Desautels, Private Citizen
Ms. Madeline Arbez, Manitoba Chiropractors' Association

Bill 36–The Registered Nurses Act

Ms. Sue Neilson, Manitoba Association of Registered Nurses

Bill 37–The Licensed Practical Nurses Act

Ms. Verna Holgate, Manitoba Association of Licensed Practical Nurses

Bill 38–The Registered Psychiatric Nurses Act

Ms. Annette Osted, Registered Psychiatric Nurses Association of Manitoba

Bill 39–The Medical Amendment Act

Mr. John Laplume, Manitoba Medical Association
Dr. Ken Brown, College of Physicians and Surgeons

WRITTEN SUBMISSIONS:

Bill 26–The Physiotherapists Act

Ms. Paula Moreira, Yellowhead Physiotherapy and Athletic Centre
Ms. Lynda Loucks, Private Citizen
Mr. Neil MacHutchon, Canadian Physiotherapists Association

MATTERS UNDER DISCUSSION:

Bill 26–The Physiotherapists Act
Bill 36–The Registered Nurses Act
Bill 37–The Licensed Practical Nurses Act
Bill 38–The Registered Psychiatric Nurses Act
Bill 39–The Medical Amendment Act

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Clerk Assistant (Patricia Chaychuk): Order, please. Will the Standing Committee on Indus-

trial Relations please come to order. We have a vacancy for the position of Chairperson. Are there any nominations.

Mr. Edward Helwer (Gimli): Madam Chair, I would like to nominate Mr. Dyck, the member for Pembina.

Clerk Assistant: I am just Madam Clerk, not the Chair. I am sorry.

Mr. Helwer: Okay, fine.

Clerk Assistant: Mr. Dyck has been nominated. Are there are other nominations? Seeing none, Mr. Dyck is elected the Chair.

Mr. Chairperson: Okay, before we move ahead we need to elect a Vice-Chair. Is there a nomination for a Vice-Chair?

Hon. Jack Reimer (Minister of Urban Affairs): I would like to nominate Mr. Helwer.

Mr. Chairperson: Mr. Helwer has been nominated. Are there any others? Is it by agreement of committee that Mr. Helwer will be the Vice-Chair? [agreed] Thank you, then we shall proceed.

This evening the committee will consider the following bills: Bill 26, The Physiotherapists Act; Bill 36, The Registered Nurses Act; Bill 37, The Licensed Practical Nurses Act; Bill 38, The Registered Psychiatric Nurses Act; and Bill 39, The Medical Amendment Act.

To date we have had a number of persons registered to speak to the bills this evening. I will read the list of the registered presenters aloud. I shall start with No. 1, Mr. Terry Woodard–and this is on Bill 26–No. 2, Dr. Anthony Wright; No. 3, Neil MacHutchon; No. 4, Gloria Gallant; No. 5, Jason Hallock; No. 6, Roland Lavallee; No. 7, Susan Morrow; No. 8, Kelly Robert Milan; No. 9, Madeline Arbez and Dr. Greg Stewart; No. 10, Mark Garrett; No. 11, Marc Arbez; No. 12, Murray MacHutchon; No. 13, Evelyn Lightly; and No. 14, Dr. Ken Brown.

There are two walk-ins. Number 15 would be Ruth Barclay-Gordon; and No. 16, Brenda McKechnie.

Then, moving on to Bill 36, we have one presenter, Sue Neilson; Bill 37, one presenter, Verna Holgate; and Bill 39, Mr. John Laplume and Dr. Ken Brown.

To date, or at least at this time, no one has registered on Bill 38.

If there are any other persons in attendance who would like to speak to one of the bills before the committee this evening and who have not already registered, please see the Chamber staff at the back of the room to register and your names will be added to the list.

In addition, if there are written items to be handed out to the members of the committee, 15 copies are required. If assistance is required to make the photocopies, please contact the Chamber branch staff at the back of the room and the copies will be made for you.

The next item of business that the committee needs to consider is which bill to hear presenters on first. There are two presenters on the list for Bill 26 who are from out of town and one presenter on the list for Bill 37. Did the committee wish to hear from out-of-town presenters first? What is the will of the committee? [agreed] Agreed that we hear the out-of-town presenters first. Thank you. After we have heard from the out-of-town presenters, in which order shall we hear the presenters on the bills?

Mr. Helwer: Mr. Chairman, I believe we should hear all the presenters that we can this evening and then carry it through to clause by clause after that.

Mr. Chairperson: Which order, Mr. Helwer, would you like?

Mr. Helwer: The order that they are listed.

Mr. Chairperson: The order as they are listed, that is the order in which we will hear the presenters. Is that agreed by the committee? [agreed] We will do out-of-town presenters first, and then we will go back and start with Bill 26 and take it in the order in which they appear.

Did the committee wish to use time limits for the consideration of presentations? What is

the wish of the committee? No, okay. So we will encourage brevity, short, to the point, if possible.

I would just like to note for the committee that two written submissions regarding Bill 26 have been received, one from Paula Moreira from the Yellowhead Physiotherapy Clinic, and one from Lynda Loucks, a private citizen. Copies have been placed on the table for committee members. Is there agreement to have the written submissions appear in the committee Hansard for this evening's meeting? [agreed]

Bill 26–The Physiotherapists Act

Mr. Chairperson: We will now proceed with the consideration of the presentations. I will take those with a little star beside them. I will start at No. 4 with Gloria Gallant, please, if you could please come to the podium. Possibly, just for consideration afterward, after we finish the presentations, I will open it up for questions, and I will identify both the presenter just before they answer the question and I will also identify the person asking the question, just for clarity later on. So, just a moment, and then I will ask you to give your presentation. Please proceed, Ms. Gallant.

* (1910)

Ms. Gloria Gallant (Private Citizen): Thank you for this opportunity to address the public committee regarding this proposed new physiotherapy act. I am a physiotherapist living and working in rural Manitoba, and I have been involved in the committee that drafted the legislation that you see before you. The new legislation was required to update several areas to current standards. The main area that required updating was the complaints and investigations procedures.

The advent of physiotherapy occurred in the late 19th Century in the United Kingdom. At that time, physiotherapists used exercise, mobilizations, manipulations, massage and other physical methods to assist their patients on the road to recovery. Physiotherapy spread throughout the world and has grown and flourished. Physiotherapy is currently a four-plus year university course with summer internships and a national competency-based examination required by most provinces prior to entering the profession. Academic standards are high, and graduates are independent and professional thinkers. Physiotherapists are taught a variety of techniques to be used in assisting a patient to obtain and maintain the maximum function possible for that individual. This will often include teaching patients different techniques that they can use to take charge of their own problem and manage it as much as possible. Physiotherapists work within the medical model and have good lines of communication with physicians and other health care providers.

In my practice as a physiotherapist, I have worked in Manitoba, Newfoundland, and England. My education from the University of Manitoba held me in good stead in all those various workplaces. In all of those geographical areas, physiotherapists worked in co-operation with the medical profession without direct supervision or direction. The education received as a physiotherapist includes instruction in various medical conditions and how those conditions vary from the usual conditions encountered in a physiotherapist's clinic. I remember several instances where I assessed an individual for a spinal condition and found that my assessment did not support the physician's request for physiotherapy treatment. The patient was sent back to their physician requesting further investigation.

In at least three cases that stand out in my mind the physician did further investigations and confirmed my suspicion that the problem was not as originally diagnosed but was indeed cancer. I bring these instances up to underline two points. Physiotherapists are educated to assess and treat and to recognize when physiotherapy treatment is not appropriate. Physiotherapists have a good working relationship with medical practitioners. When there is doubt in our minds as to the diagnosis, we can readily obtain the assistance we require.

The current situation in Manitoba is direct access of the public to physiotherapy but requires that physiotherapists communicate and consult with physicians. In practice, this means that a patient will often attend a medical clinic to obtain a physician's letter to bring to physio-

therapy. This communication from the physician states something such as: low back pain; please assess and treat. The physicians know that that is all the information required, and if more is needed, we will ask for further investigations. Patients can very easily tell me the same thing: My low back hurts. Could you please check it out and help me out?

The change in the act before you poses no danger to the public. Indeed, the ability to go directly to the physiotherapist will save the public some health care dollars with no increased risk. When the Physiotherapy Association consulted the College of Physicians and Surgeons concerning our proposed new act, no concerns were raised. I personally do not do manipulations in my physiotherapy practice. I use many other techniques such as mobilizations, exercise and lifestyle intervention. If a patient requires manipulations, I send them to a physiotherapist qualified to do that. The professional standards in place for physiotherapists to do manipulations are very high. Manipulation techniques are restricted to those physiotherapists who are specially educated to do them. The physiotherapy college in Alberta is currently developing a new competency standard for manipulations. It will undergo a national validation procedure and will be followed in Manitoba when it is available.

Like most physiotherapists in Manitoba, I carry malpractice insurance that is available through our professional organization. The new act before you would allow the Physiotherapy college to require that all physiotherapists in Manitoba carry malpractice insurance. The majority of physiotherapists carry this insurance already except those therapists who are covered by their employer. The new act would ensure that there is 100 percent compliance. The main reason for redoing our act was to update our complaints and investigations procedure to bring it in line with current thinking. Our present act allows for a finding of professional misconduct but does not allow for findings of lesser problems.

The new act identifies other areas that would require redress in some fashion. It would allow for mediation when it was felt that the issue was one between the complainant and the physiotherapist, allow for counselling or require courses to rectify an identified problem area. It would also allow for censure of a physiotherapist, impose conditions on a physiotherapist's entitlement to practise physiotherapy as well as to suspend or cancel a member's registration and therefore their right to practise physiotherapy.

In Manitoba, the current Physiotherapist's Act was proclaimed in 1981 with a prior act in 1974. The following are the major changes in the new proposed act and the benefit to Manitobans. The first one is a name change from association to college, which provides a stronger position for public protection. Physiotherapists and physical therapists would be protected titles which is less confusion for the public. There would be more public representatives on council and committees which allows for more public accountability. There would be direct access to physiotherapy, which is a simplified process for the public and less costly to health care.

The function of the college would be clearly stated to serve and protect the public interest, not the interest of the profession. There would be a simplified two-stage complaints process, more accessible and more accountable to the public. The complaints process will have more option. The public interest would be better served in correcting problems through mediation, censure, monitoring practice requiring a member to take courses, et cetera. The regulations provide for establishing a continuing competency program, which again is public protection. The regulations provide for a requirement that members carry professional liability insurance, which is again public protection.

The council may appoint practice auditors to review the operation of a physiotherapy practice. This is public protection both proactive and reactive. The new act would allow compliance with the AIT which allows for portability across Canada and therefore more availability of physiotherapists. It allows for simplified categories of registration which is less confusing to the public, and it allows for an annual report required to the Department of Health, which is more accountability to both the government and to the public.

The Physiotherapists Act before you is good legislation for all Manitobans. It corrects problems in our current act, strengthens the public accountability and protection of the public aspects of the act and brings Manitoba in line with the majority of other Canadian provinces. Patient safety is foremost for all of us, and this new act allows us the mechanisms to ensure that safety is indeed always the main issue.

Mr. Chairperson: We wish to thank you for your presentation. There are several questions upcoming. I will ask the minister to pose his first.

Hon. Eric Stefanson (Minister of Health): Thank you very much, Mr. Chairman, and thank you, Ms. Gallant, for your presentation. I only have two questions, because you have addressed a couple of the issues that have been of some concern. You touched on the issue of liability insurance, and it is my understanding today that any physiotherapists who are in private practice as a basis of good business carry liability insurance. But I know that through the preparation of the regulations, the College of Physiotherapists will be consulting, will be reporting back to us, and we as a government will have to pass those regulations.

I take it from your comments that it would be your inclination and that you would be supportive that malpractice insurance be mandatory for individuals who are going to be practising a private practice.

Ms. Gallant: Actually, I would support it being mandatory for all physiotherapists, even those working inside a hospital setting, just because there is always the option of the hospital covering you and then suing you in return. So my opinion would be that it should be mandatory for everyone.

Mr. Stefanson: The other issue is then the issue of manipulations that you speak to in some detail in your presentation, and once again that the College of Physiotherapists will be reviewing that issue under the regulations, making recommendations basically relative to the whole issue of the requirements to do manipulations, particularly as it relates to spinal manipulation. So again, I just ask for your comments on that process and your views.

Ms. Gallant: I would assume that the process would be that we would write regulations setting up standards for manipulations, and because the College of Physiotherapists in Alberta are right now looking at competency standards for manipulations that will be undergoing national validation, those competency standards are probably what we would use. Our professional association has already standards in place, but because our particular profession is divided into a professional and a licensing association, it is not the licensing association standards; it is professional standards. All physiotherapists follow those standards anyway, but the new national competency standards would be what I would hope we will adopt.

* (1920)

Mr. Dave Chomiak (Kildonan): Thank you for the presentation. Curiously, both the issues that I was going to address have been approached and then broached by the minister. I just do want to clarify the issue of malpractice, because that issue has come up.

In your presentation you indicated the fact that right now most physiotherapists, if not all physiotherapists, are covered by liability insurance. I presume that one of the issues that will arise will be, well, now that there are direct referrals and perhaps there may be a greater need for this, and I will assume from the minister's comments and your comments, as well, the regulations which are not mandatory which say may require members, I assume that the association will be recommending–and since you drafted legislation–they get mandatory. Is that correct? I would also assume that the government will be proceeding on that basis. Is that a correct assumption?

Ms. Gallant: That is a correct assumption. I do not think it is written as mandatory in the regulation section of the act, but if you require malpractice insurance by all members, regulations are enforceable.

Mr. Chomiak: I will also be looking to the minister in terms of a confirmation later on when

we go clause by clause through that particular section. Of course, the other issue is the issue of manipulations. You had indicated in your practice that if there was an occasion, you do not specifically handle manipulations yourself, but you do direct them toward someone who is a specialist or has more experience in that area. Is that the general pattern that is followed? Can you give me information on that, generally?

Ms. Gallant: Yes, I would think so. I work in rural Manitoba, so my setting is slightly different than most of the people that work in Winnipeg. But, when there is somebody who needs a manipulation, I encourage them to go further afield, which is usually Winnipeg, in order to get that specialty area. There are chiropractors in the area, and I have sent people to chiropractors as well. But I encourage them to go to a specialist in the area.

Mr. Gary Kowalski (The Maples): As the other speakers have said, we have received a lot of letters as MLAs from a number of physiotherapists and also from chiropractors. The two issues that the chiropractors brought forward was the issue of malpractice insurance in manipulation and you have covered that. I was just about to ask you the question about your relationship with doctors. You explained that doctors have been referring matters, and sometimes you have referred them back to the doctors. I was going to ask you what is the working relationship with chiropractors and physiotherapists. You have said that there have been occasions when manipulation was required and that you would refer people to chiropractors where I was led to believe that they were a competing service. Are they complementary services, physiotherapists and chiropractors, or are they competing services?

Ms. Gallant: Well, you can look at it both ways. In my opinion, the best treatment for the patient is what all of us are supposed to be looking toward. I do not work in a private practice setting so my pocketbook does not dictate my referrals. So in the instance where somebody needs a manipulation, I will send them to whoever I feel is the most qualified, and I have on occasion sent them to a chiropractor. The majority of the times, I will send them to a physiotherapist because I know a physiotherapist's training much better than I know a chiropractor's training. But, living in rural Manitoba, that means a long drive for most people, and if that drive is not acceptable to them, then I have suggested that they go to a chiropractor.

Mr. Kevin Lamoureux (Inkster): Just for clarification, you indicate that you do not do manipulations. Is that because of your choice? Right now you would have the training any physio can do manipulations, but you choose not to do it. Is that a fair assessment?

Ms. Gallant: No, I have the background training to do manipulations, but I have not taken the courses that are required to do manipulations in all areas. There are a couple that I could do, but I do not work full time as a physiotherapist, and I feel that you need to be practising on a regular basis in order to continue doing a procedure like that, so I have chosen not to do those procedures that I am trained for because I do not feel comfortable doing them.

Mr. Chairperson: If there are no further questions, thank you very much for your presentation. We will move on to our next out-of-town presenter; that is No. 6, Roland Lavallee, please. Okay, if you could please start with your presentation as soon as you are ready. I do not want to rush you. Mr. Lavallee, thank you, proceed.

Mr. Roland Lavallee (Private Citizen): Good evening, honourable ladies and gentlemen, colleagues, members of the public, as well as, members and representatives of the Manitoba Chiropractors' Association. I wish to thank you for the opportunity to address the committee here on Bill 26, The Physiotherapists Act. I do so as a private citizen but also as a physiotherapist with a unique perspective, I think, on some of the major issues being discussed by the one group opposing aspects of this legislation. It might be useful for the committee to understand my perspectives, how they were formed.

I graduated from the University of Manitoba in 1983. Since that time I have been active on a number of different committees. Some of note, I have been chairperson of the Manitoba Sports Physiotherapy Division of the Canadian

Physiotherapy Association; chairperson of the Private Practice Physiotherapists of Manitoba. Currently I am chair of the discipline committee for the Association of Physiotherapists of Manitoba, and I have had that responsibility for the last five years or so. I have had my own practice since 1986, and I have worked under the banner of Windsor Park Physiotherapy.

I have, as many of my colleagues here, extensive postgraduate clinical training. My specialty is in orthopedics. At this time in Manitoba, there are five physiotherapists with my clinical designation of a Part B. Part B practitioner is that practitioner who has studied and been tested for orthopedic specialization, as well as, peripheral and vertebral manipulation

There is another section of specialist. They have a Part A, and they have been tested in peripheral manipulation and many of the aspects of our orthopedic specialities. So there are five of us here in Manitoba that have that Part B designation. We are termed Fellows of the Canadian Academy of Manipulative Therapy. We are responsible for assisting Manitoba physiotherapists who have an interest in gaining clinical knowledge and experience in orthopedics and peripheral manipulation. I teach orthopedic courses, and some of those courses include peripheral manipulation and I refer to peripheral as wrists, ankles, knees, et cetera. I am working towards becoming an examiner for the Canadian orthopedic examination system of the Canadian Physiotherapy Association.

I understand there are two major issues being discussed and opposed, I might say, by the Manitoba Chiropractic Association. The two main issues are this, and they have been alluded to already, that is the continuation to include manipulation in the physiotherapists' scope of practice, as well as the provision to allow the public to gain direct access to physiotherapy services.

Regarding the first item, I hope you all realize that manipulation has been in a physiotherapy act since the '50s, so this is not a new aspect of treatment. My specialized orthopedic training places me, I think, in a situation where I am the practitioner as well as a teacher in this aspect. I want you to understand the Canadian orthopedic and manipulative training system is highly regarded in Canada. Canadian physiotherapy associations form part of the International Federation of Manipulative Therapists, that is the IFOMT. Our system of clinical training for orthopedic physiotherapists is copied throughout the world, and what I mean by the world, I am talking about the Netherlands, Australia, England, the United States. Canadian physiotherapists have reason to be proud about our world reputation in the practice of manipulation and orthopedic training, in the training of that and in the practice and research of manipulation. Indeed, I am proud to be part of that education system also.

* (1930)

Quite simply, ladies and gentlemen, physiotherapists have been practising safe manipulation in Manitoba and in Canada for years. There is no evidence to suggest that Manitoba physiotherapists are unsafe practitioners of manipulation. That reflects on my work and the efforts of my colleagues in Manitoba and Canada. As chair of the discipline committee of the association, I would hear any investigated cases on malpractice of manipulation. In my tenure, there has not been any. In the past there have not been any complaints made by groups or the public regarding manipulation and physiotherapists. That is a matter of public record. I think this reflects on the expertise, the training and the clinical judgments of physiotherapists to choose manipulation or to not use manipulation. It illustrates a very high standard of practice that you should all be made aware of when you are considering the merits of Bill 26.

Our system of education is different than that of chiropractors. The philosophy of orthopedic and manipulation offers, in my opinion, Manitobans a choice. Our system of training works in providing effective--but the issue here is it also has been proven to be safe. Manipulation across the world is practised by many professions, if you did not know, physiotherapists, chiropractors, certified athletic therapists; some physicians have been trained, physiatrists, who are physical medicine specialists, osteopaths. No single group in the world has exclusivity on the training or the practice of manipulation, and, in my opinion, nor

should they. Please make sure that Manitobans continue to have a choice. Our standards in manipulation have a solid basis and they are safe. The evidence speaks for itself.

The second issue I want to discuss here is the issue of direct access. When I was preparing my presentation I thought I would give it a title. I was trying to think of something flashy. So the first thing that came to mind was First Contact: The Landing of Bill 26. Now if any of you in the committee here are sci-fi enthusiasts, you know that term "first contact." I am a sci-fi person; I love that sort of first-contact concept. However, when I sort of thought about it, I realized that that is not the right title, that is wrong. Ladies and gentlemen, physiotherapists landed a long, long time ago. We have been a key member of the health care team long before I graduated. Direct access, in my opinion, is a rite of passage for our profession. In fact, I stand here before you today defending a policy that I essentially have had since graduation. Let me explain that.

This is an example of a patient who comes in with Blue Cross. Contrary to what some groups may think, patients choose my services without a direct patient's referral. That is, they come, they make an appointment with me, I assess their problem, I decide a course of treatment. Current legislation requires that I treat that patient in communication with a physician. I do that by either a telephone call or a short note. Insurance plans, like, I said, Blue Cross, do not require a physician's referral to pay for my services.

Ms. Gallant said, and I will emphasize again, the public has had the chance to obtain direct access by a physiotherapist since 1981. Bill 26 is not a large leap of faith for you to take. In fact, I think it is a small refinement of a system that already works in Manitoba. I hope you will be hearing presentations from the faculty at the University of Manitoba. They will provide you with the details of the pathology and differential medical conditions training that physiotherapists get. The public, as well as groups, have never made a formal complaint to the association in regard to our duty of care when patients were assessed and given a physiotherapeutic diagnosis. We are firmly entrenched in the team approach.

The College of Physicians and Surgeons is fully supportive of the proposed legislation. I feel they have got good reason to be confident in our skills to assess musculoskeletal conditions and refer other conditions on to medical doctors for further evaluation when necessary. We work closely with medical practitioners, and therefore we have quick and easy access to relevant information that is required to provide safe, efficient, and effective physiotherapy care.

I want to clarify something because the point has been brought up earlier, that is, the issue of malpractice insurance. I have practised since 1983. I have had malpractice insurance since then. I have owned a clinic since 1986. Nobody would work in my clinic without malpractice insurance, and I am totally confident that would be the case in all of the private clinics in the province, that it already exists. No one would be there to support us in the event that we would have taken a malpractice suit.

We all recognize the escalating costs in medical care. I am sure you are familiar with the burden of the long waiting lists and the busy medical practices. They are all understood by you. You need not be an economist to realize that direct access to physiotherapy services can provide an effective means of alleviating some of those burdens. There are many instances– sprained ankles, athletic injuries, back strains– when a physician's time is saved when his or her patient visits the physiotherapist first and a treatment plan is set out. That initial physician appointment can often be a rubber stamp. Yes, you have a sprained ankle, go see the physiotherapist. Well, it is not Blue Cross that paid for that physician's visit; it is the Manitoba medical system that did. There is an automatic saving there for Manitobans when it is literally speaking a rubber stamp.

Many doctors would agree that this situation often occurs in their practice. The College of Physicians is not concerned with the ramifications of Bill 26 when it comes to direct access. No opposition has been forwarded except by the MCA, and, with all due respect I am not familiar

with the evidence, and I underline the word "evidence," that would justify their concerns.

My final point illustrates how early consultation to a physiotherapist is paramount in providing good rehab care. I refer you to the last page of my presentation that has a coloured form here. This is an excerpt from a larger study, and I have a 54-page document. I wanted to save a tree and not provide 15 copies of that, but this is an excerpt of that analysis.

I form part of a network of physiotherapy clinics across Canada. We have taken aspects of our physiotherapy files, and we have looked at 25 factors. Some of them include: how long did it take to see a physiotherapist? Is someone taking medication for their primary diagnosis? Is there a rehab consultant involved? Twenty-five factors. We wanted to do that because we wanted to extract information right at the beginning of patients' care so that we could recognize who is at risk for chronic, perhaps long-term rehab, and if we can recognize those people, we would maybe be able to pull in other disciplines–psychologists, occupational therapists, whatever–to try to assist in their care. So this excerpt, I will just illustrate quickly, this is from 3,000 physiotherapy files. That bank that we have now in Canada is over 10,000 files, so the information is coming and will be more and more reliable as time goes on. The large arrow on my presentation is highlighting the main factor that existed in patients who had chronic problems.

I do this as a way to provide you with some proof how direct access could help Manitobans. Lag time of referral is the term that I want to use here, the time it took for someone to see a physiotherapist. If it took greater than four weeks, the person was in treatment longer, and success, that is, return to work, took longer to get them back to work. So the earlier the better is the point I want to make about that. Get them into physio earlier. Direct access will help that. Get them active, in my terminology.

The final illustration that I will want to say is how physiotherapists have worked well here in the system in Manitoba. This here is the final document I have presented to you, the one that has the blue highlight on it. This document is the Standards of Excellence Program that was jointly developed between the private practice group in Manitoba and Manitoba Public Insurance Corporation through the guidance of Ernie Toews, Don Gaudry, Dr. Neil Creighton [phonetic] who formed the MPIC contingent of this. We developed a joint program on how patients injured in motor vehicle accidents could be educated, made active early to reduce the chances of chronicity.

This is a unique document, ladies and gentlemen–this does not exist anywhere else in Canada–where a motor vehicle insurance company and a professional group came together with ideas to help the public to reduce any chances of chronicity.

I want to read just the very top thing here: MPIC acknowledges the positive contribution made by the private practice physiotherapists of Manitoba in the creation and implementation of the Standards of Excellence Program.

Physiotherapists are ready for Bill 26. I feel strongly that you will better serve the public in Manitoba if you allow its quick passage. Thank you.

* (1940)

Mr. Chairperson: Thank you very much for your presentation. We will open it up for questions. The honourable minister first.

Mr. Stefanson: Thank you, Mr. Lavallee, for a very thorough presentation. I will not ask you again to reiterate comments on malpractice or manipulation, recognizing we have about 16 presenters, but you did speak at some length about the issue of public access, and again I appreciate and agree with your comments. My understanding is not unlike many other health care professionals, that your code of ethics, the Association of Physiotherapists requires physiotherapists to request consultation with or refer to colleagues or other members of the health care team when such is necessary in the interest of optimum patient care. Could you offer any further comments on that?

Mr. Lavallee: I have been doing that throughout my time as a physiotherapist. Any

time a patient would have seen me, if they came without a referral I would have always communicated to that practitioner that I have seen their patient, what is their problem, do you have any concerns, if you do, please contact me back.

There are a number of instances where patients have come with an incorrect diagnosis, and we just sort of phone call discussed it back. We are here for the patient and having patients as quickly treated and as quickly understanding their problem the better, and that has just been the normal course. I do not see Bill 26 changing any of that. If anything, as I mentioned before, it will refine it.

Mr. Chomiak: Thank you for the presentation. Because there are a lot of presenters I do not want to go over a lot of territory, so I am going to ask you a question that perhaps–I wanted to have a little bit better understanding of the designations under Part A, Part B, et cetera. I do not know if I should pose that question to you or perhaps–I note that there is going to be a presenter from the University of Manitoba who might better be able to. Either way, can you give me a layperson's sort of a breakdown of those designations, please?

Mr. Lavallee: The orthopedic training that exists in Canada today follows the Canadian Physiotherapy Association's specialization document. That is a sort of a step procedure. Currently graduates from the University of Manitoba, and this is where faculty might answer the question better, are graduated with the first level of course termed the E1V1. "E" stands for extremity; "V" stands for vertebral. So if someone does an E1V1, they graduate; they are interested in orthopedics, they carry on. They take an E2V2. Then they take an E3V3. After they have taken a V3 and they have this desire to challenge the examination system in Canada, that examination system happens through three steps: a written presentation, an exam, as well as a practical examination. That practical and written examination happens once in Canada every year. So people prepare to do this exam. They have gone through their first levels. They take their examination. They earn a Part A. A Part A allows them, that the association recognize that they are skilled and have been tested in peripheral manipulation, specialized orthopedic assessment, and they are able to teach some of the lower level courses, the E1s, the E2s, the V2s.

The next step: you take a V4. The V4 is the manipulation course. After you have taken the V4, most people take another V4 from another practitioner in Canada because there are very specialized people in Canada that teach these courses. Once you have taken your V4, you can challenge the Part B exam. Once you have challenged the exam, successfully completed, the association would consider you capable of peripheral and vertebral manipulation as well as teaching the higher level of courses. That is the system. That is how you get your A and B.

Mr. Chomiak: Mr. Chairperson, I presume that there might be an argument about the issue of manipulation and the level of training under these designations. Can you comment on that?

Mr. Lavallee: My first comment might be some of the comments I have made. The proof is in the pudding. There has never been any action against a physiotherapist in Manitoba. Our system in Canada works.

I made a comment about so many professions do it differently. There are osteopaths. There are even osteopaths who practise in Manitoba. It exists in Quebec. It exists in the States. Osteopaths manipulate. Is it the same training as mine? No.

So I guess I make the comment, the training certainly can be debated, and I would not want to compare my training to that of a chiropractor. I am not a chiropractor. I am a physiotherapist. Our philosophy is embedded in our educational system. Quite simply, it is safe. That is, I think, the issue that might be the concern. I do not know of any evidence to the contrary.

* (1950)

Mr. Lamoureux: Yes, I did have a couple of questions for Mr. Lavallee. When today little Johnny or Jane is walking through a field, steps in a hole, sprains their ankle, you indicate that if Johnny walks over or is carried over to your clinic, there is an obligation for you to consult a physician in order to treat little Johnny.

I am interested in terms of a percentage basis, and I can appreciate you are going to have to guesstimate possibly, of the numbers of cases that there would be no real requirement for these individuals, whomever they might be, to have to go and see a physician prior to physio.

Mr. Lavallee: My first comment would really stem to the dollars and cents issue. It depends on the insurance company. Currently, Blue Cross is the insurer in Manitoba that will pay for the service. Great-West Life requires a physician's referral, so that Johnny, depending on mother or father's insurance plan, quite simply would have to go to see that physician and get that rubber stamp to see me.

Now you are talking about percentages. Blue Cross forms the largest component of what comes to see me in my clinic. Clearly, 80 percent of private insurance users of my services are Blue Cross, which would then sort of fit that the largest majority of those patients certainly can come in with that patient's referral. So it first of all depends on money for that patient coming in. If Johnny's parents could afford my services without an insurance, fine, they could come in, but that is a small percentage. Blue Cross forms the largest good 80 percent. If I see three or four new patients a day, 80 percent of them are Blue Cross and, for sure, daily, someone comes to see me without a referral. So figure the amount of days that that might be, and how many times that happens.

Mr. Lamoureux: Johnny hurts himself. He goes to the hospital. A registered nurse at the emergency or whatever sees Johnny. He has a really bad sprain in his arm. In order to see the physio at the hospital, Johnny would have to be referred from the doctor.

There are two things here. One is the cost factor. The other is the potential problems that are incurred as a result of Johnny maybe not seeing a physio as early as he could have had he not had to go through a medical doctor. So what sort of a cost factor is there by having to go to the doctor first? Are we talking a nominal fee? Are you talking a substantial fee? When you call the doctor's office and say: well, look, I have this patient; Blue Cross obligates me to talk to you–[interjection]

You know, there is going to be a fee to MHO. What sort of a fee are we talking about for that doctor to say, yes, you can treat that?

Mr. Lavallee: No fee. The physician does not bill to see my note or to hear a phone call from me. I suppose that is perhaps, I will say, from the government's side, the beauty of direct access is my services are paid through third-party payers. Private practice is not supported by Manitoba Health Services Commission. If a patient is seen in the hospital, then fees are incurred. The fee issue is, when they see me without a doctor's referral, there is no cost to the system. It is all borne by a third party, Blue Cross, Great-West Life, whatever.

If they are seen in the hospital, that is a different issue. I do not know the current fee of what MHSC has to pay the hospital to see a physiotherapist. I do not know that fee.

Mr. Lamoureux: I just want to be clear on the point. If Johnny wants to see you and Blue Cross says: well, you can only see Johnny if you have a doctor's referral–

Mr. Lavallee: Blue Cross never does that.

Mr. Lamoureux: Okay, are there any organizations that would require that sort of service?

Mr. Lavallee: Yes, Great-West Life, for instance. If Johnny's insurance company is Great-West Life, Great-West Life in their stipulation says you need to see a physician first for us to pay the services. So then the cost to MHS, to the health services, does occur. I would say maybe from the perspective of Manitobans, I would like to see the day that Great-West Life does not make it a requirement of their insurance policy. It currently exists for Blue Cross, who is the largest insurer in Manitoba; it does not for others. This is just another step in that direction. I anticipate corporations like Manitoba Public Insurance Corporation, once Bill 26, or hopefully if Bill 26 is enacted, that the use of a physician in those kinds of simple strains and sprains in a motor

vehicle accident, we will not require that physician visit to start the system.

Mr. Chairperson: Thank you. Are there further questions? If not, thank you very much for your presentation.

We will move on. As was previously indicated under Bill 37, Verna Holgate has indicated that she is not from out of town. So we will proceed and stay with Bill 26 and move up to No. 1 now, Mr. Terry Woodard, please. Do you have any copies for distribution?

Mr. Terry Woodard (Private Citizen): No, I do not.

Mr. Chairperson: Okay, please proceed, Mr. Woodard.

Mr. Woodard: Mr. Chair, fellow committee members. Further to what many of my colleagues up previous to myself have said, I would like to thank you for the opportunity to speak to Bill 26, The Physiotherapists Act. It is certainly, as has been touched on many times so far, a bill that is very important to myself individually and also to our profession.

My name is Terry Woodard, and I have been practising physiotherapy in Manitoba since I graduated from the U of M in 1992. Currently, I work at the Victoria Hospital.

I guess the first thing I would like to do is congratulate the government on bringing forward this legislation to the committee stage; and secondly, commend you on the consultative process that occurred prior to bringing it forward. I would also like to take the opportunity to thank both the official opposition and the third party for the attention that they have paid to this legislation up to this stage. My remarks on the bill will be quite brief.

Simply put, Bill 26, The Physiotherapists Act, is very important to Manitobans, and it is important for a variety of reasons. I would like to touch on two, and fortunately, the people speaking before me have taken it into a greater depth than I will even touch on. Number one, it will allow Manitobans direct access to physiotherapy, and I guess the way I would look at it, with the continued focus on our patients' best interests as a health care provider. We will continue to work co-operatively and in collaboration with many of the other health care practitioners, whether that be physicians, nurses, dieticians, chiropractors, whoever we feel is in the best interest of our patient to see is who we are going to continue to work collaboratively with.

* (2000)

I guess, No. 2, as has been touched on by Ms. Gallant in a lot of detail, was with regard to the public accountability and the discipline process certainly being firmed up and tightened up to ensure a lot smoother and fairer process if that need arise. During the development of the act, there was extensive consultation with many different organizations and with government. There was strong support for the act and also for the principles that it was based on. The College of Physicians and Surgeons, the Manitoba Association of Registered Nurses were two such groups who offered support for the act. I think I had chosen those two groups of the many who have offered support because they are two of the groups that we work strongest with and certainly two of the groups that we spend a tremendous amount of our time liaisoning and consulting with, with regard to how we can best serve our patients and meet their needs.

As a result of the consultative process, many suggestions and comments were brought forward, and they were studied and they were acted on. The result is the act that you see before you. In my opinion and many others, as a result of this, this act is in the best interest of Manitobans with regard to health care delivery. Issues such as professional liability can now be acted on as a result of Bill 26. We have certainly gone into a lot of detail about that already. The bill now gives the College of Physiotherapists, if the bill is to be enacted, the right to require members to carry the insurance. So again, one of the many concerns that was brought forward by a particular group I think we have certainly touched them and dealt with many times over.

I guess from a personal perspective, I am able to comment on the tremendous impact that

myself and many of my colleagues have on Manitobans in terms of dealing with their health care needs. Helping a person overcome a disability, trauma or an injury, many times it is difficult to explain what that can mean to not only the patient or the client but also to the person who is providing those services. The ability to work as closely as we do with patients certainly means a tremendous amount to us, and again one of the areas that the act can certainly help us deal with.

As a key member of a collaborative health care team, the betterment of our patients, their health, their well-being and their future is a reward for us. I think the term "team" is something we need to touch on because that is how we approach it. Earlier in my presentation, as well as many of my other colleagues, we talked about what "team" means. We are not out in the health care field practising independently. We are working collaboratively with other agencies and with other disciplines. Sure each of the team members may bring a different frame of reference to the table, but the goal is to provide quality health care, quality safe health care.

For the continued delivery of excellence and physiotherapy care, I would urge you all to strongly support Bill 26. I would like to thank the Chairman and the committee for the time.

Mr. Chairperson: Thank you very much, Mr. Woodard. Are there questions?

Mr. Kowalski: Ms. Gallant, when she made her presentation, and I believe the previous presentations are in private practice and you work in the hospital setting, she talked about malpractice insurance not only for those in private practice but for those working in hospitals and clinics. The rationalization there was that even if the hospital carried liability insurance, the hospital could cover the patient but then they would sue the physiotherapist. Her assertion that would make all physiotherapists obtain malpractice insurance, would you agree that that would be something that would be accepted by all physiotherapists? Number 2, who would pay for that malpractice insurance? The individual therapist, the employer, who would pay for it?

Mr. Woodard: I think you bring up some very valid points. Right now the way that it works, as Mr. Lavallee had mentioned, my understanding is that in terms of private practice, all or essentially all of the members would carry liability insurance. Working in a hospital, at this point in time, the hospital covers my liability insurance. The comment that perhaps there would be the potential that the hospital may sue the physio, it was important for me to hear those kinds of remarks from Ms. Gallant, because it is certainly something that I would support in terms of all the members of the physiotherapy community having their own private insurance, whether they work in a private practice or in a hospital. So it was certainly a new point for me to consider, but I think I would have to strongly agree with her.

Mr. Kowalski: Do you have any idea how much malpractice insurance would cost for an individual therapist, any idea what the costs are of that?

Mr. Woodard: With regard to obtaining malpractice insurance, the majority of the physiotherapists in Manitoba would obtain their insurance from the Canadian Physiotherapy Association. I believe it is about $100 or $125 a year for the insurance. I could not tell you what level that would cover up to, but, again, it is sort of the standard amount that most physios would obtain.

Mr. Chairperson: Are there further questions? If not, I wish to thank you for your presentation. Thank you very much.

We will move on to our next presenter, Dr. Anthony Wright, please. Dr. Wright. Do you have copies for distribution? We will just wait until your copies have been distributed. Okay, please proceed, Dr. Wright.

Dr. Anthony Wright (Physiotheraphy, University of Manitoba): Thank you for the opportunity to speak to you this evening. Just to introduce myself, I am Dr. Tony Wright. I am here this evening as head of the physiotherapy program at the University of Manitoba. To give you some of my background, I hold an honours degree in physiotherapy. I also hold a masters

degree in manipulative physiotherapy, and I completed my Ph.D. studies conducting research, investigating an experimental model of joint pain. I have also been very active over the last decade or so in conducting research in the field of musculoskeletal pain and also in relation to manual therapy and looking at the phenomena of manipulation induced analgesia, in other words, the pain relief that occurs after manipulative treatments. I publish extensively in that area, and I am also a member of the editorial board for the journal Manual Therapy.

Now I am just relating these points just to indicate to you that I do have some background in relation to the areas and topics that are currently under discussion. Let me begin by saying that I feel there has been a good deal of general satisfaction with Bill 26. Its initial drafting spanned a significant period of time with substantial consultation both within the physiotherapy profession and with other professions and stakeholder groups. On the whole, there has been a good deal of satisfaction with the legislation as it is being drafted and currently stands. At a late stage in the consultation process, the chiropractic profession, through the Manitoba Chiropractors' Association, made a submission to government in which they raised a number of objections to the new legislation.

These last-minute objections represent the only significant negative comments that have been raised. I would like to take the opportunity to deal with a number of those points of objection and to show you how they have been addressed. The initial objections can essentially be summarized as follows: there was some objection to protection of the title physical therapist; there was objection to the public having direct access to physiotherapy services; there were concerns about the level of professional liability insurance held by physiotherapists; there was objection to the fact that physiotherapists practise manipulation; and, there was a belief from the chiropractic profession that in some way they should act as gatekeepers for all those who would practise manipulation techniques.

* (2010)

Many of the previous speakers have addressed a number of these issues. I want to take the time to deal with each of these issues in turn and to show you how they have been or are being addressed beginning with protection of title. Following initial consultation with the Manitoba Chiropractors' Association at a meeting called by Mr. Carson, it was made clear that protection of the title physical therapists does not prevent other professional groups, including medicinal and chiropractic, from using physical or physiological therapies. This appears to have satisfied MCA, and, in subsequent correspondence, there has been no further objection to this particular aspect of the bill.

Direct access to physiotherapists is essentially a fact of life for all Manitobans under the current act. Currently, members of the community can visit a physiotherapy clinic and obtain treatment. Under the existing legislation, the physiotherapist is expected to consult with the patient's physician, but they do not necessarily require an initial referral from that physician. They do not necessarily end up being examined or fully examined by the physician. The present legislation simply recognizes and streamlines what is, in essence, a de facto situation.

Concern raised by the chiropractic association was that physiotherapists do not have the necessary examination and diagnostic skills to act as primary-contact practitioners. In subsequent correspondence, I have outlined the training received by physiotherapy students, and it provided assurances that physiotherapists are very well trained in this area. The physiotherapy profession has for very many years realized and recognized that physiotherapists practise as de facto first-contact practitioners, and in many jurisdictions around the world this role is fully recognized in legislation. As responsible educators for physiotherapists who may subsequently practise both in Manitoba and in any other part of Canada or elsewhere in the world, we realize that our graduates will be fulfilling this role and for many years we have educated them accordingly.

Now I would just like to relate to you something that I read and picked up on a website for the American Chiropractic Association, and

it is quite interesting in terms of describing the role and expertise of chiropractors and is of very great relevance, I think, to the role and expertise of physiotherapists. In answer to the question what is a doctor of chiropractic, it says chiropractors are first-contact physicians who possess the diagnostic skills to differentiate health conditions that are amenable to their management from those conditions that require referral or co-management. Chiropractors provide conservative management of neuromuscular skeletal disorders and related functional clinical conditions, including but not limited to back pain, neck pain and headaches.

If I were asked to provide a description of the role of physiotherapists practising in the muscular, skeletal or orthopedic field, it would be that physiotherapists are primary-care practitioners who possess the diagnostic skills to differentiate health conditions that are amenable to their management from those conditions that require referral or co-management. Physiotherapists provide conservative management of neuromuscular skeletal disorders and related conditions, including but not limited to back pain, neck pain and headache. As you can see, there is really no significant difference. Of course, the strong overlap is one of the major factors underlying the chiropractors' objections.

If you are involved in presenting one of two competing products, it is imperative that you create difference between those products in order for the consumer to wish to partake of the service that you are providing. Much of the chiropractic correspondence has laboured on the topic of differential diagnosis. It is very clear to me that neither profession, physiotherapy nor chiropractic has access to the laboratory and imaging facilities necessary to be able to undertake a full differential diagnosis in complex cases.

What they possess is the training and screening skills to determine that a patient might have a spinal tumour, for example, and that they should undergo further investigation. They are not equipped to determine if that tumour, for example, is a latent benign lesion or a high-grade malignant lesion. Such differentiation is obviously important to the specific management of that patient's condition. The skills for full differential diagnosis in those areas rests with the medical profession. The skills that the physiotherapist possesses are the ability to recognize those conditions and problems in presentations that fall within their normal scope of practice and to recognize those patients with unusual or complex or presentations that cast some doubt about the potential diagnosis and to make referral to the necessary services for further investigation to be carried out. There is no evidence that physiotherapists in Manitoba have been failing in this role, and I am sure that the medical profession would have raised objection if there were any concern about the ability of physiotherapists to fulfill this primary-contact role.

It is interesting to note that, while in correspondence from the Canadian Chiropractic Association there was a recommendation that physiotherapists should not be granted primary-contact status until they meet minimal base standards. I note that in the most recent correspondence from the president of the Manitoba Chiropractors' Association such a recommendation has not been included. I am therefore assuming that chiropractors have accepted the assurances and information that has been provided and that they are now withdrawing or withholding their objection to physiotherapists acting as primary-contact practitioners. The failure to recognize that physiotherapists can and do fulfill this role essentially flies in the face of reality.

On the issue of professional liability insurance, the MCA seems to lack a full understanding of the legislation and the current situation. Currently, most physiotherapists in private practice hold professional liability insurance, as you have been previously advised. Most therapists working in the public system are covered by insurance held by the institution.

The new legislation has been drafted to specifically give the college the power to create regulations requiring all physiotherapists to obtain and maintain professional liability insurance. It is my understanding that such regulations will be developed and that they will have to be approved before the act is applied. Clearly, APM has recognized this issue, and it

has ensured that it is addressed through the new legislation.

Essentially, from my point of view, the question of professional liability insurance is essentially a nonissue. It is very clear that the new legislation provides for it and that once the legislation is in place and the regulations are prepared, that will become a reality.

The main points of continued debate revolve around the use of manipulation by physiotherapists. To some extent, this is not surprising. Currently, chiropractors in Manitoba receive government reimbursement for spinal manipulation. Physiotherapists in private practice, on the other hand, who provide spinal manipulation or peripheral manipulation services do not receive such reimbursement. The physiotherapy profession has made representations to government seeking equitable funding for their services and pointed out that Manitobans who receive manipulative treatment from physiotherapists are to some extent disadvantaged. What better way to secure your financial monopoly in this area than to use legislative means to prevent other professional groups from providing this service?

In relation to the use of manipulation and the safe application of manipulation by physiotherapists, the first point to make is that manipulation is not a new treatment for physiotherapists. In some correspondence and in some parts of the chiropractic literature, there is a strong inference that physiotherapists have only recently begun to use manipulation. I would like to explicitly state that this is incorrect. Physiotherapy predates chiropractic as an organized profession. The physiotherapy profession emerged in England in the 19th Century. Chiropractic, on the other hand, began in North America.

* (2020)

At an early stage, the Chartered Society of Physiotherapy accepted manipulators into its ranks, particularly in the north of England, and manipulation has been a component of physiotherapy practice essentially since then. While it is not the case that all physiotherapists practice manipulation, the one point to realize there is that physiotherapy is a very broadly based profession. People practise in a number of different areas, including, for example, in the pediatric field, in the cardiorespiratory field, in the neurological field, the management of stroke and the management of patients with amputations, as well as practising in this musculoskeletal orthopedic field. There have always, however, been some physiotherapists who utilize manipulation.

In the late 1950s and 1960s, there was an international awareness of the need to provide high-quality education in manipulative therapy for physiotherapists and also for physiotherapists to conduct research on this topic. This led to the formation of the International Federation of Orthopedic Manipulative Therapists. This is the organization that regulates physiotherapy education and manipulation around the world. Canadian physiotherapists have been very prominent in IFOMT, including the fact that we are privileged to have had a Canadian, Mr. Bob Sydenham, as past-president of IFOMT. The essential point is that physiotherapy education in manipulation exists under an international regulation and accreditation process.

In Canada, training in manipulative physiotherapy is essentially a two-tier process. At the undergraduate level, physiotherapists receive extensive training in musculoskeletal examination, clinical reasoning, the application of a number of joint mobilization techniques, as well as a restricted number of high-velocity manipulations. A system then exists which has been fully expanded for those physiotherapists who specialize in the musculoskeletal field to undertake further postgraduate training in this area. Those physiotherapists who follow courses leading to the Diploma of Advanced Orthopaedic Manual and Manipulative Physiotherapy undertake further training, including instruction, in a greater range of manipulation techniques. Any suggestion that physiotherapists practising manipulation are inadequately training in this area is incorrect. There is a very well-established, thoroughly reviewed and regularly updated process of training.

Let us just consider the topic of safety since many of the objections raised by the chiropractic profession have essentially worked around the concept of safety concerns. The first point to

make about manipulation is that it is essentially a very safe treatment. Compared to many drug treatments or surgical interventions, for example, the risks are very low. For example, in all of the published trials of the use of manipulation, evaluating outcomes from manipulation, there have been no reported adverse effects within any of those trials. One major difficulty, however, is that an adequate scientific literature does not exist to really define what the proportional risk is for various adverse events that might occur with manipulative treatment. While manipulation in general is a very low risk procedure, we cannot ignore the fact that manipulation of the upper neck in particular does carry with it a small risk of very serious complications, including stroke and death. Sadly, the main at-risk group for these adverse reactions are relatively young, previously fit and healthy individuals. It, therefore, behooves all professionals using manipulation to exercise due care when manipulating particularly the upper neck or upper cervical spine.

The physiotherapy profession provided leadership in addressing this safety issue in the late 1980s when it introduced mandatory vertebral artery testing for all patients in whom a physiotherapist is contemplating an upper cervical manipulation, so that we are aware of the risks and steps are taken to try to minimize those risks. Unfortunately, the bottom line is that with the best will in the world and with all of the best procedures being followed, there is still a small random risk attached to these procedures.

Now there is one particular aspect or piece of information that has been presented in both the brief that was forwarded to the government and in subsequent correspondence about the issue of differential risk for different professional groups. I would like to deal with this in some detail, because I have as a scientist great concerns about the way in which some of that information has been presented to you.

The brief presents one piece of information or one piece of data from a study in the United States and suggests that chiropractors carry out 94 percent of all spinal manipulation in the U.S. They then take data from another study of the world literature reviewing reported cases of adverse outcomes following manipulation and suggest that by combining those figures from both studies that there is a case suggesting increased risk for nonchiropractic manipulators. Now this is a gross aberration. Essentially, for example, they have not presented any figures for the percentage use of manipulation for all professional groups worldwide. We have heard before that both physicians, physiatrists, osteopaths, chiropractors and physiotherapists use manipulation worldwide. In many, many other countries, the number of chiropractors and the percentage of manipulation being carried out by that profession would be much less. So to compare a figure from the United States to figures obtained from the world literature is a gross misrepresentation.

Also, if you consider this figure of 94 percent, it refers not to the number of spinal manipulations carried out. It refers to the number of insurance claims for manipulative therapy. Closer analysis of the data shows that under this claim heading were included claims for physical medicine visits, office visits and X-rays. In relation to first visits, only 39 percent of claims were actually for spinal manipulation, and of follow-up visits, 66 percent of claims were for spinal manipulation. So the figures do not add up even to justify the suggestion that in the United States, chiropractors carry out 94 percent of spinal manipulation.

The bottom line on this issue is that we essentially do not know what the relative utilization rates for manipulation are for different professional groups. We have no good information or data on the rates of adverse events for different professional groups. Quite simply, the research that might support such assertions has not been done.

Also, in some items of correspondence, various members of the chiropractic profession have tried to promote the concept that technical proficiency guarantees safety. In other words, the technical skill of manipulation guarantees safety. I would like to make a couple of important points which demonstrate that technical proficiency alone is no guarantee of safety in this area. The first is that addressing major safety issues in manipulative therapy is largely a cognitive skill rather than a motor skill

or a technical skill. You need to be thinking rather than doing while you decide whether it is appropriate to carry out a manipulation on a particular individual or not.

* (2030)

All of our students are provided with extensive lists of contraindications to the use of manipulation, points from the examination or assessment of a patient that would specifically exclude the use of manipulation for that patient. This is a skill that we expect students to acquire at an early stage in their training even before they become technically proficient in the use of manipulation techniques. In other words, even at the early stage of training, learning and acquiring manipulative techniques, we want to ensure that people are safe to the extent that they are thinking about the particular presentation of a patient and determining whether or not this person falls within a group or a category or has some other disorder that might preclude the use of manipulation. This is there from the early stages.

The other point I would make is that the most serious adverse events that occur with manipulation are largely random events. In other words, the fact that you have a lot of experience, the fact that you have a great deal of technical skill, the fact that you have the cognitive and reasoning skills that are necessary does not guarantee that no adverse event will occur for a patient in your care. The risk is small, and there is a random element to that risk. We take all the steps that we can to provide people with the technical training and the reasoning that is necessary, but we are aware, and we make our students aware, that nevertheless there is a risk. There are no guarantees.

In a number of letters the chiropractic profession has recommended that they should have some sort of undefined role in determining the competency of physiotherapists to manipulate. Why is the physiotherapy profession resistant to this suggestion? The reasons are simple. Firstly, we are a responsible profession with a long history of using these techniques. We have demonstrated our responsible approach by developing internationally validated training programs. We have many highly skilled practitioners within our own ranks who are more than capable of setting and evaluating standards in this area. The physiotherapy profession in Canada is providing leadership in this area by developing written documentation defining the competencies required to practise manipulation. As an independent profession, we are more than capable of regulating our own affairs. Granting a gatekeeper status to some other profession over our skills and practices would be a very dangerous precedent. It is essentially like saying that dentists should evaluate the competency of medical practitioners to examine the oral cavity. It essentially flies in the face of the normal independence of professional groups.

Now I am coming to the finish of my presentation. Let me pose a question. Why are the chiropractors really objecting to this legislation? If their primary concern was with the safety of Manitobans, we might expect to have heard about more specific safety problems here in Manitoba. We might have expected to have heard about specific incidents or problems. Why is it that the arguments that we read in their brief are well-worn statements that have been promulgated in a number of other jurisdictions, in the United States, elsewhere in Canada, and in other places in the world? Why is it that last year or in the last year or so physiotherapists in Michigan, Tennessee, New York, Virginia in the United States, and in Alberta here in Canada have had to mount successful defences of their right to provide manipulation as a treatment? Is there some sort of national or international process at work here? Could it be that the objections have more to do with protection of market share by the chiropractic profession?

Let me read to you some brief extracts from a document prepared by the chiropractic profession to provide them with potential plausible scenarios for the future of their profession in a rapidly changing health care marketplace. It provides a realistic evaluation of where the competition lies. The document states that, on the one hand, there will be no major competition from medical doctors. They essentially write off competition in that direction. On the other hand, there is likely to be new competition from osteopaths, with British and French osteopaths bringing their traditional

emphasis on manipulation and holistic care back to North America and into other world regions. Additionally, North American osteopathic skills will refocus on their manipulative roots as the oversupply of physicians provides a more competitive marketplace in general. There will be significant competition from the physical therapy profession. In Scandinavia, Australia and New Zealand and increasingly elsewhere, a significant number of PTs are doing formal postgraduate courses in manipulation.

Elsewhere in the document they go on to state that the loss of market share–and just mark that term market share–will be larger than it might have been, principally in the U.S., Canada and Australia because of the difficulties in developing a clear identity and role for chiropractors as providers of expert manual care of the neuromusculoskeletal system. The chiropractic profession is clearly concerned about defining its role and protecting its marketplace. What better way to achieve both objectives than to impose legislative restrictions on those other professions that provide such care.

I will conclude by saying that the Legislative Assembly here in Manitoba should take no part in creating artificial legislative distinctions between professions who provide basic aspects of care to Manitobans, to all Manitobans. Bill 26, as it is currently formulated, is a very satisfactory piece of regulation. It requires no amendments. Thank you, gentlemen.

Mr. Chairperson: Thank you for your presentation. There are a few questions. I will ask the honourable minister first and then Mr. Chomiak.

Mr. Stefanson: Thank you, Dr. Wright, for also a very comprehensive presentation. As well you have been copying me on some of your correspondence to the department, I think at least two letters dealing with many of the issues. In fact in one of them you pointed out that the University of Manitoba has been providing teaching physiotherapy since I believe 1960. You went on to talk about, with this legislation, that we are really following what you described, I think, as a very well-trodden path in recognizing the role of physiotherapists as primary contact health care providers. Would you care to just take a moment to elaborate on your knowledge in that area in terms of what has happened elsewhere, either in Canada or even internationally?

Mr. Wright: Elsewhere in Canada, within other provinces, physiotherapists are primary contact practitioners. That, as I said, knowing that a significant number of our graduates will go to practise in other provinces, we provide training to meet that standard. It is my understanding that primary contact legislatively has been in place in some areas of the world since the early 1970s. So, essentially, as a legislative procedure, this particular act follows a path of legislation that began about 1974.

Mr. Chomiak: Thank you for the presentation. I just have one question. You note that physiotherapy profession provides leadership in addressing the safety issue in the 1980s when it introduced mandatory vertebral artery testing for all patients in whom the physiotherapist is contemplating an upper cervical manipulation. Could you just elaborate on that for me?

* (2040)

Mr. Wright: That was a process that was essentially established by the Australian Physiotherapy Association in approximately 1987-88 when that association developed a protocol for vertebral artery testing in patients in whom physiotherapists were contemplating manipulation so that there is a structured process both in the subjective aspect of the examination to look for symptoms that might be indicative of vertebral artery insufficiency and then to conduct testing procedures to determine whether movements of the upper cervical spine produce symptoms that might be indicative of vertebral artery insufficiency and then to sustain the patient in the position in which the manipulation will be carried out for a period of time in order to determine whether any symptoms occur.

Now subsequent to the IFOMT meeting in Cambridge in 1988, many other groups, physiotherapy groupings, throughout the world brought this into their professional protocols. Now I need to say that that particular procedure does not guarantee safety, but it does indicate

that we take that aspect of safety very seriously, that we evaluate the patients fully, and if there is an element of doubt in the physiotherapist's mind, they are then obliged to carry out other procedures rather than manipulation.

That is something, as I have said, for the last decade or so that has been an aspect of practice.

Mr. Lamoureux: I wonder if you can indicate how many, to your knowledge, provinces in Canada actually have direct access today.

Mr. Wright: I would have to say that I am a relatively–well, I am not even a new Canadian as yet, I am a relatively new person to this country, and I cannot give you specifics on that. I am sure that some of my colleagues, particularly Brenda McKechnie from the Association of Physiotherapists of Manitoba, will be able to give you specifics. My understanding is that at least four provinces have that. I could stand corrected.

Mr. Lamoureux: I guess, finally, a two-part question. One is, in the States, and we recognize the reporting tools that were used to getting the 94 percent in terms of manipulation, but having said that, can you give us any idea in terms of what percentage guesstimate that physios would do here in the province of Manitoba for manipulation?

Mr. Wright: It essentially would be an guesstimate because the research has really not been done. That is my main point on this, that the research studies, the international studies, that would be required to determine who is providing this service, how often or how frequently they are this service has simply not been done. Any figure is a guesstimate.

Mr. Lamoureux: 10 percent? 80 percent?

Mr. Wright: I have no idea. I would not hazard a guess.

Mr. Chairperson: Thank you very much for your presentation, Dr. Wright. Then we will move on to our next presenter, please. Mr. Kowalski, on a point of order?

Mr. Kowalski: Not a point of order, just a procedure, whatever. For people who are not here, are they going to be moving down to the bottom of the list and be called a second time if they are not present or they do not answer, or will they be dropped if they are not here?

Mr. Chairperson: What is the will of the committee? We need to determine that. It would be my understanding that they would be called twice, then would drop to the bottom of the list. Is there agreement by the committee to proceed in that fashion? [agreed]

Mr. Kowalski: The reason I ask that question is I believe a number of the private citizens who are listed as presenters here are physiotherapists. I believe that a lot of them will present the same information. Depending on the presentations from the Manitoba Chiropractors' Association and the College of Physicians and Surgeons, they might not find it necessary to present. It might expedite the matters if we called on presenters No. 9 and 14 before we go through the others. I am just talking to some of the people in the audience. A number of them are physiotherapists. It would be repeating the same presentation. Depending on what comes from those two, it might expedite matters tonight.

Mr. Chairperson: I thank you for that information. What is the will of the committee?

Hon. James McCrae (Minister of Education and Training): I have very quickly canvassed the audience myself and, you know, the honourable member for The Maples just may have a point here, that we might want to perhaps, if there is a way to do that yourself, Mr. Chairman, go ahead, but I think that he has a good idea here.

Mr. Chairperson: What is the will of the committee? [agreed] Okay. Then with the will of the committee, we will move on then to No. 9. I would like to call on Madeleine Arbec and Dr. Greg Stewart, the Manitoba Chiropractors' Association. I assume, is it Dr. Greg Stewart? Okay. Do you have a presentation for us? Thank you. Then we will wait until we have received those and then I will ask you to proceed once we have received them. Please proceed, Dr. Stewart.

Dr. Greg Stewart (Manitoba Chiropractors' Association): You will be happy to know I am the only chiropractor presenting this evening. I am speaking on behalf of the association in this matter.

My name is Dr. Greg Stewart. I am governor to the Canadian Chiropractic Association. I was appointed by the Manitoba Chiropractors' Association. I am a past president of the Manitoba Chiropractors' Association and member at large. Reference was made earlier about being a team member and used to working with other people and other professions. I am proud to say that I am the chiropractor for the Canadian track and field team. That is something I am very used to, working as a team effort with physiotherapists, athletic therapists, massage therapists, and physicians. I also believe my record in my community speaks favourably for my use of the various professions when I feel necessary for my patients' well-being.

Firstly, I will not address research, because I do not have the references that we provided earlier. As well, I have no way of qualifying or making comment on the passages that were read by other individuals this evening. So I apologize. If any of the information is necessary to clarify our position you may have received some correspondence on, please let us know.

I would like to begin by thanking the members for the opportunity to make this presentation on behalf of the Manitoba Chiropractors' Association, which I will refer to as the MCA, regarding Bill 26. I would like to begin by commending the Association of Physiotherapists of Manitoba for a beneficial and thorough consultation process, as well as the Department of Health for their assistance.

The MCA and the chiropractic profession is acutely sensitive to the issue of turf protection by various health professionals, as the chiropractic profession has often been subject to various monopolies and misrepresentations since our inception. I especially take somewhat offence to terms such as utilizing legislation to pursue monopolies and turf. It is because of our profession's experience with these issues that the chiropractic profession respects the regulatory legislative process and the right of the self-governing professions to regulate themselves.

As articulated throughout our correspondence, the MCA's presentation this evening is not intended to block legislation, nor is it intended to slight our colleagues in physiotherapy. We come to you this evening to bring what our profession believes to be legitimate concerns regarding public safety. The opinions presented to you this evening are based on consultation with our national association, the Canadian Chiropractic Association, our provincial associations, as well as the Canadian Memorial Chiropractic College feedback.

Our objective this evening is to share with you constructive amendments to the legislation which will allow the process to continue and be completed within its desired time frames, increase the public safety and protection in the act regarding spinal manipulation, build a collaborative effort for areas and activities commonly performed by doctors of chiropractic and physiotherapists.

Our presentation this evening will focus on two issues that resolve around our collective concerns as health care providers, the safety of the Manitoba public we serve. The first issue, and it has been addressed earlier and I apologize for any redundancy, is regarding public liability and malpractice insurance.

* (2050)

In 1985, a worldwide insurance crisis occurred as a result of the disaster in Bhopal, India, at the Union Carbide plant. Consequently, reinsurance was no longer available for professions who did not have their own protective agencies. Insurance carriers notified the doctors of chiropractic and their licensing bodies that their incident coverage was not attainable at a level required to ensure adequate public protection due to the world-wide shortage of insurance. Because of this, the CCA created the Canadian Chiropractic Protective Association which would protect the chiropractic profession and the public from prevailing mood fluctuations of the insurance industry. This model for the chiropractic coverage was

designed after the Canadian Medical Association plan.

Currently, chiropractic patients are protected by a plan which insures doctors of chiropractic to a total of $4 million a year per practitioner, $2 million per incident. The coverage is mandatory for all Canadian chiropractors. During our meetings with the physiotherapists, it was disclosed by the physiotherapists of Manitoba's representatives that malpractice insurance is optional for physiotherapists in Manitoba. Why is this an issue? Harrison's Principles of Internal Medicine, 12th Edition, states "Every medical procedure whether diagnostic or therapeutic has the potential for harm," regardless of the competency level of the practitioner.

Historically, physiotherapists were under medical referral and were protected under the auspices of the medical practitioner. However, the reality is that private practice physiotherapists must now assume the burden, as well as the benefits, of being primary contact health care providers and provide the proper public liability insurance for the protection of the public and themselves. Every other self-regulatory mainstream health care profession has mandatory malpractice insurance. This leads us to the following recommendation.

While we are pleased to hear that mandatory malpractice insurance would be within the regulatory process, it is imperative that the practitioners who are assessing patients independently maintain adequate malpractice insurance to protect the patients and themselves. Secondly, the MCA has been assured that this matter will be dealt with through the regulatory process which is under the discretion of the physiotherapy association.

The current regulatory section of the act states that the therapists may–and you brought this out earlier, leaving this issue to the discretion of the association. For this reason, the MCA recommends the following: that current legislation incorporate a provision which states a mandatory requirement for all private practice physiotherapists to maintain proper public liability insurance. The amount of insurance coverage could be fixed by the regulation, for example, $1 million or other such higher amount as fixed by the regulations from time to time. If the legislation does not address public liability, then a commitment should be made by the physiotherapy association to ensure that it will become mandatory and it will co-operate with the appropriate government body to fulfill its commitment.

The second issue was regarding spinal manipulation. Chiropractic training was an evolutionary process that was developed to ensure safety, efficacy and proper application of chiropractic procedures. The primary form of treatment by chiropractors, as you are well aware, is spinal manipulation. The MCA believes that spinal manipulation is a specialty which requires training and daily use of the techniques. The MCA's concern is that there is insufficient protection built into the current legislation for the protection of the public. It was stated earlier that we might not be aware of how many people are treated with manipulation in this province, but we know how many people are treated by chiropractic in this province. We know how many procedures were undertaken, as a doctor is only reimbursed for the actual spinal adjustment, and we know that there were in excess of 130,000 different Manitobans treated last year with spinal manipulation by chiropractors.

Canadian doctors of chiropractic treat approximately 120,000 Canadians on a daily basis, spinal manipulation being the primary tool. As a doctor of chiropractic, I will perform an average of a thousand different spinal manipulations every week. The association believes that in light of the inherent material risks involved that the public has a right to expect that anyone who is legitimately allowed to conduct spinal manipulation will have met a uniform set of standards and competencies.

A recent inquest into the unfortunate death of a chiropractic patient brought forth a set of recommendations regarding spinal manipulation. The doctor of chiropractic involved was exculpated of any responsibility. The incident, which was a first in the profession in more than a hundred years of practice, was extensively reviewed and resulted in a set of recommendations from the coroner of Saskatchewan, and these are enclosed in your handout. These

recommendations were distributed to all provincial Ministries of Health and are applicable to anyone conducting spinal manipulation.

Recommendation five of the report states: increased communication and collaboration among all specialities in health care to maximize benefits and minimize risks inherent to cervical spinal manipulation treatments. It is because of the inherent risks involved with spinal manipulation that all Canadian doctors of chiropractic had adopted the following well before the incident. Firstly, there were written, informed consent forms, and there is one in your package. These outlined the risks and rights of patients to be informed of the risks prior to treatment. In other words, when a patient comes into my office, with the other information they fill out, they also sign an informed consent form talking about the various risks they may be subject to and their rights about whether to extract information and of course talk about their right with all procedures, that being to refuse care if they are unsure of the risks and they are not risks that they are willing to undertake given their condition. These are signed and witnessed in our offices prior to any spinal manipulation being undertaken. Also, there is mandatory malpractice insurance coverage to protect the practitioner and the public.

Special risks require special training, and for a physiotherapist to conduct spinal manipulation, the MCA believes that they should have to meet the same or comparable standards to the stringent standards applied by the Canadian chiropractic profession. For example, in the case of acupuncture, the MCA members are to provide evidence that the acupuncture training has been received through an accredited Canadian Council of Chiropractic Education institution, as well demonstrate that they are in good standing with the Chinese Medicine & Acupuncture Association of Canada. They must also show proof of proper malpractice insurance before they are permitted to practise acupuncture.

The policy was established as the board of directors of the MCA did not purport to establish a regulatory force upon an area outside of their expertise. They did, however, want to ensure public safety all ongoing with the procedures that are taking place within chiropractic offices. This took place while I was president myself, and we felt we were stuck with a situation we did not feel that we were the experts in that field, and therefore we actually transferred some of the regulatory processes and competency standards to another organization which we felt would have a level of standing that we felt would ensure public safety when they were in our offices receiving acupuncture.

* (2100)

The issue the MCA has with the current legislation, as it relates to spinal manipulation, is that the physiotherapists are permitting their members to perform a procedure for which they do not have the same or comparable training and expertise as doctors of chiropractic. There seems to be a reluctance on their part to recognize that spinal manipulation is a highly specialized technique for which doctors of chiropractic have the most experience. Chiropracty is primarily devoted to spinal manipulation, and the profession brings a wealth of experience as primary-contact practitioners. It is our understanding that a select few of the physiotherapists in Manitoba have undertaken the advanced training sessions in spinal manipulation in order to achieve this satisfactory level.

The profession brings these issues forward in the spirit of co-operation for public safety in this very delicate area. The legislation, as it is currently worded, and that is wording regarding manipulation, does not address the potential ambiguity and as a consequence does not safeguard the public against the inherent risk of spinal manipulation.

Therefore, it leads us to the following recommendations. The MCA recommends the current legislation be amended with the following proviso: (1) The addition of a subsection 2, paragraph 3 (a) proviso: no physiotherapist shall perform any spinal manipulation unless the physiotherapist satisfies all criteria established and is certified as a specialist in spinal manipulation in accordance with all applicable standards and regulations.

The MCA would suggest–this is not part of the amendment, by the way–that the consultation

process could be undertaken in the following manner: the Minister of Health would appoint a committee consisting of representatives from the Department of Health, the physiotherapists of Manitoba and the Manitoba Chiropractors' Association charged with the responsibility of establishing agreed-upon standards and competencies. The association is aware of the current work being undertaken in Alberta and believes that Manitoba could consider Alberta's framework within its solution.

Reference was made earlier to the competency standards being established in Alberta but it was not stated that the Canadian Chiropractic Association and the Alberta College of Chiropractors were consulted and are part of the team in order to establish these competency levels. So this is not new ground. I will personally be part of the process in Alberta looking at the competency standards.

It was never our intention, and I have to reiterate this, that we do not believe that manipulation or spinal manipulation for that matter is exclusive to chiropractic. That kind of approach I could not even stand here and speak to you about today because it would be so obviously self-serving that I would be very embarrassed to make such a claim. It comes down to procedures based on skill level and hopefully the intellect and the physical capabilities of the person performing the procedure regardless of his academic background. Anyone in this room, whether physiotherapist or chiropractor can be trained properly and I think to a satisfactory level to perform these procedures given the fact they have to go over a certain bar. So I have to reiterate that is not why we are here today.

In conclusion, the MC believes that the new legislation will allow a new level of co-operation between the chiropractors and physiotherapists previously unattainable with the current legislation. As you remember, the current legislation talks about consultation with medical practitioners. We have had very little direct contact with physiotherapists because of the restrictive manner of the previous legislation. For example, I could send a patient directly to an athletic therapist but for a physiotherapist they would have to get permission from the medical doctor to treat my patient. As you can imagine, that circumnavigation does not do the patient any benefit.

It is not our intention also to be gatekeepers for physiotherapy. As stated earlier, they are self regulatory. We would like to be part of a process. We do not wish to be included within their regulations. The MC brings these recommendations in the spirit of joint co-operation and with public safety as its primary concern.

There exists a new level of responsibility inherent with the legitimate status of primary contact health care provider and the physiotherapist must meet the standards not unlike all other mainstream health care providers. Current national research shows that the trend towards alternative health care is rapidly growing with more than 55 percent of people seeking alternative health care in the last five years. Though the physiotherapists have conducted spinal manipulations under their legislation, the fact is the number of patients who will seek spinal manipulation will be considerably more than previously due to the wealth of research showing the benefits. Therefore the number of physiotherapists conducting spinal manipulation will increase considerably more, and so will the risk.

Although the regulatory section of the act may address the issue of malpractice, this decision is left to the discretion of the physiotherapist while all other mainstream health care providers are required to have malpractice insurance for the safety of all involved. Its final manipulation is a specialized technique to physiotherapists not unlike acupuncture. The health care practitioner has an inherent responsibility to ensure that a consistent and uniform standard is applied for the safety of the patient.

The MCA hopes that the committee will consider these two amendments, or variations of them, aimed at protecting everyone involved. We thank you for your time and would be pleased to address any of your questions.

Mr. Chairperson: Thank you very much for your presentation, Dr. Stewart. I will ask the honourable minister to start with questions.

Mr. Stefanson: Thank you very much, Dr. Stewart, for your presentation this evening and for your contributions towards this issue over the last several weeks. I really want to deal with your few recommendations very briefly. Your first one on page 3 of your submission you deal with the issue of malpractice liability insurance, and further in your brief, I believe it is the bottom of page 6, you refer to the other mainstream health care providers being required to provide the insurance. My understanding of that is, in most of those cases, if we look at our Medical Act or our Midwifery Act or our nurses acts, all of those have been done through regulations. You have heard the comments here this evening from a number of individuals associated with physiotherapy relative to the opportunity to address this issue through regulations, not unlike these other professional organizations. At the very bottom of page 3 you basically say that. You say if the legislation does not address it specifically, then you are looking for an indication or commitments that it will be implemented and so on.

There is some merit in doing it through regulations in terms of having discussions about amounts, having discussions about the impact if you are in private practice or if you are employed by an additional employer, so I guess I would ask you, in light of what you have heard here this evening, based on at least four presentations, are you more comfortable that that issue can and will be addressed through the regulation-setting process?

Mr. Stewart: Very much so. I was happy to hear much of the comments made today, especially the personal comments where their own feeling was that it should be mandatory. I think that matters to me more than anything else does, because I am sure they are very reflective of members of their association or they would not be here speaking today, and I am sure that there would not be a huge vocal opposition if it was made mandatory.

Mr. Stefanson: Thank you very much for that comment. The other one is your other recommendations which are basically on the bottom of page 5, top of page 6. I guess my question is very similar there as well. You are well aware, I believe, that under Bill 26, the College of Physiotherapists can again make regulations requiring completion of postgraduate training and in high-risk manipulations as a prerequisite to the use of such techniques. I believe at least one previous speaker, Ms. Gallant I believe, touched on that issue again in some detail and ask you a similar question. Are you more comforted and confident that again this issue can be addressed through the regulation process?

Mr. Stewart: I really do believe it can be part of the regulations; however, there may have to be a qualifier under the word "manipulation" in the legislation, that we separate manipulation. I have no doubts that people who graduate from physiotherapy can adjust elbows, wrists, ankles, et cetera, but I am just trying to make a distinction between manipulation and spinal manipulation and that specific reference to spinal manipulation be made within the act, like I said earlier, in making reference to the regulations which would outline the competencies. Obviously, when it is in the regulations, the various competencies could be modified over time to a satisfactory level.

Mr. Chomiak: Thank you for your presentation. It is curious to me. There was a time when ministers and I would not generally agree on questions and responses, but I am finding today that we are concurring, and the minister has asked several of the questions that I had intended to ask. But are you at all persuaded or convinced in terms of the information that was provided by Dr. Wright concerning the protocol as it relates to what I understand to be cervical spinal manipulations which, from what I understand, is the issue at risk? Is the fact that there is a protocol in place and has been in place for a decade that provides for testing and an assessment procedure, does that not provide you comfort with respect to your proposed amendment?

Mr. Stewart: A reference was made earlier about no test gives a guarantee, and Dr. Wright is accurate in that situation. In the Saskatchewan incident, for example, I understand that those screening procedures were applied in that instance, so obviously it minimizes risk but absolutely does not remove it entirely. I believe that everyone has an obligation to perform procedures that are recognized by the courts in

these areas and instances to be the expected course of examination prior to delivery of these procedures, so therefore they are rather universal. As far as having a regulation to be provided, we do not have. It is part of our education process, and the informed consent part talks about the procedures that will be undertaken.

Now the request from the coroner, like I said earlier, they talked about further research–and you have a copy of it–talking about further research into screening procedures for the various risk procedures. I think reference was made to not having access to some equipment. I mean, personally in my office I have diagnostic imaging, X-ray equipment at my disposal when I feel it is necessary right there and then. We also have access to a CT scanner in Winnipeg, which we can have access to immediately.

* (2110)

So we feel that the encumbrances we have regarding diagnostic procedures are the ones that are forced upon us. We are trained in laboratory diagnosis, urinalysis, venipuncture, et cetera. It is just the current legislation as it lists in our act in Manitoba which precludes us from utilizing these other screening tests, these other screening procedures.

Mr. Chomiak: Did I understand it correctly that you had included the five recommendations from the coroner's report in our presentation, Dr. Stewart, because I do not have those.

Mr. Stewart: I am sorry, we have it here with us. We can get copies made if you wish.

Mr. Chomiak: The issue of informed consent, of course, is a requirement regardless of legislation. It is a legal requirement for all professions regardless of whether or not it takes a written form, as I understand it, but you are saying it is a matter of course for chiropractors to provide for mandatory written informed consent.

Mr. Stewart: It is dictated by our insurance carrier that it is mandatory.

Mr. Lamoureux: Mr. Chairperson, like the member for Kildonan (Mr. Chomiak), the minister did take a couple of the questions away in terms of what it is we are wanting to pose, one of the benefits of leading off, I guess.

In looking at physiotherapy as a profession, it was encouraging in listening to your recommendations. I think in most part the concerns that you raised with the committee were, in fact, addressed in previous presenters. A good example of that is the liability insurance where you state a million dollars, for example, as a minimum or higher. From what I understand, at least in the private sector, it is considerably higher than that. So it just kind of reinforces the profession in its ability to be able to do the things that are necessary in order to demonstrate public safety, if I could put it in that fashion.

In spinal manipulation, I posed a question to the speaker prior to you in terms of percentage. You have some numbers in terms of what it is that you would do. Can you give the committee any idea in terms of overall spinal manipulation what chiropractors would be doing percentage-wise in the province of Manitoba?

Mr. Stewart: In the province, like I said earlier, we treat 15 percent of the population, approximately, per year, and over a five-year time frame, we are treating approximately 40 percent of the population. We have very accurate statistics regarding our procedures, and every one of those visits involved spinal manipulation. The ones that did not involve spinal manipulation are not in the numbers from the Department of Health.

So we had about 126,000 patient visits regarding spinal manipulation which were billable to the Department of Health. We had another 15,000 or so visits via MPIC, and I believe it was in the neighbourhood of 5,000 to 7,000 different patients regarding WCB.

Mr. Lamoureux: Would you have any idea in terms of, and, again, it could be a guesstimate, the possible numbers that the physiotherapy profession would do?

Mr. Stewart: No, I do not. I just know by, again I am speculating, feedback from patients and the contact I have with various well-established organizations in this province, that

they found it incumbent upon themselves to bring a chiropractor into the facility in order to provide, and it is the most widely recognized physiotherapy institution that brought a chiropractor on staff, as there was increased demand and the fact that chiropractic is well identified, for lack of a better word, with the procedures.

Mr. Lamoureux: Finally, Mr. Chairperson, you indicate in the report that you believe the legislation will bring to a new level more positive rapport. If I put myself in the shoes of being a physio, it reads: no physiotherapist shall perform any spinal manipulation unless the physiotherapist satisfies all criteria established and is certified as a specialist in spinal manipulation in accordance with all applicable standards and regulations.

Given the presentations that you have heard this evening, is it not safe for committee members to believe that that particular profession does have the abilities from within to protect the public's best interests, given their history in doing spinal manipulation?

Mr. Stewart: The way the act is currently written, and I asked this question very pointedly during our deliberations, was whether physiotherapists may adjust or manipulate–we use the word "adjust" in our profession–a spine upon graduation, and the answer was they would not. That is not my question, I said. I said may they. Are there any repercussions? Is there anything written that precludes them from performing these procedures other than their own self-identity as far as being able to do the procedure safely? The answer was, yes, they may, based on the way it is worded in the act.

Personally, if we are leaving it up to everyone to make judgment calls on what they may or may not do and what they feel they can and cannot do, we would have a very, very quick little examination process and regulatory process because everyone would be doing only what they really can do and would not ever do things they cannot do.

I think that legislation cannot be drafted in a way that there is that sort of latitude in judgment, and the responsibility in health care legislation, in particular, is such that it is defined when it is possible to be defined. I think in this situation that they have acknowledged the fact that they have continuing education; they have recognized experts in the field; they have postgraduate courses to reach a level of competency which I believe I could be satisfied with and most people in this room could be.

In chiropractic, we do not have postgraduate training to attain different levels of manipulation. The postgraduate training that occurs takes place in utilizing different approaches, ongoing continuing education and reinforcement of techniques and broadening the procedures that can be developed, but, overall, when a chiropractor graduates from chiropractic college, he is capable of manipulating basically every articulation of the body as a requirement for graduation. So, therefore, the steps that are in place in their own field I think reflect the need for the ongoing education in order to perform spinal manipulations safely and, not only that, effectively.

We are a little bit hypersensitive about these things, because when things go wrong it is called chiropractic procedures; when things go right, they are called manipulation procedures. So we are so highly identified with spinal manipulation that in various articles and literature through the years, it is tagged on as a chiropractic type of procedure. This has been causing misrepresentation in the literature regarding stroke incidents, et cetera.

Mr. Chairperson: Thank you very much for your presentation, Dr. Stewart. We will move next on our list then, as indicated before, to Dr. Ken Brown, please, College of Physicians and Surgeons. Dr. Brown, do you have copies?

Dr. Ken Brown (College of Physicians and Surgeons): I do not have a presentation that is written, if I could just make a few comments.

Mr. Chairperson: Certainly, go ahead, please, Dr. Brown.

Mr. Brown: The college has been involved in health regulation for 128 years. I have not been there that long, but it is getting that way, 25 years this year. So I have seen a lot of health regulation. I have seen a lot of physiotherapists.

I think it is quite apparent to us and has been apparent for many years that the physiotherapists are capable of independent practice. We opened discussions with the physiotherapists approximately six years ago, and I would stress that it was the college that initiated the conversation in order to encourage the move toward legislative reform.

There seemed to be some difficulty in achieving the reform, largely because, I think, of the political process about which you would know more than I, and, as a result, we advised our department, our minister, a few years ago that we would like the indulgence of the government if we were to accommodate the physiotherapists by interpreting the language as liberally as possible, so that we could recognize a reality which is that our patients have been having independent access to physiotherapists for several years.

It is quite true that the physiotherapists work with physicians, but that is because it is a common body of knowledge and because there is a very clear recognition of the risks that are associated with many of the procedures.

* (2120)

Mr. Edward Helwer, Vice-Chairperson, in the Chair

So they have developed the self-discipline which makes it possible for them to discriminate between those situations with which they are safe to proceed and those with which they are not. In our experience, we have had a good communication with the association. We have never have had reason to be concerned about the quality of the investigation should it be brought to their attention.

So, in short, we would regard them and we do regard them as well-educated. They have sound training in many specialties. We believe that changes are appropriate, and I think the most important thing that possibly I could speak to is that they follow very good regulatory processes. I think in this respect the processes that they have demonstrated they can function with should see reality in their legislative change.

Mr. Vice-Chairperson: Thank you, Dr. Brown. Are there any questions for Dr. Brown?

Mr. Lamoureux: Doctor, I am curious, from your perspective in terms of the spinal manipulation, do you have any limitations or qualifications that you would put with that particular procedure, with physios personally?

Mr. Brown: We have a lot of experience with manual therapy of manipulation with respect to the medical profession itself, and none of these processes are things that all physicians would attempt to undertake. So I would have to start with that sort of background.

The physiotherapists would be more akin probably to the branch of medicine called physical medicine. In that branch of medicine, you will find manipulation used quite frequently. The physiotherapists have, understandably, developed particular skills with respect to manipulation. I think it is commendable that they have shown, through their research, that you do have to develop tests in order to screen your patients to ensure that it is appropriate to proceed with manipulation.

Mr. Chairperson in the Chair

Mr. Lamoureux: I guess, finally, you would not then have any personal problem with their being able to regulate that aspect of their own profession?

Mr. Brown: I do not think the issue is whether or not every single physiotherapist is prepared to manipulate or not to manipulate. The issue is can the profession itself control its members in a way to guarantee safety to the public, and it is in this respect that we have confidence in the physiotherapists.

Mr. Chairperson: Thank you very much for your presentation, Dr. Brown. We will move back to No. 3, Neil MacHutchon, please. Neil MacHutchon. Okay, then we will move on to our next presenter, Jason Hallock, please. Defer, okay. Move on to Susan Morrow, please. Ms. Morrow, please proceed with your presentation.

Ms. Susan Morrow (Canadian Physiotherapy Association): Thank you, and I will be very brief. I just come to you this evening as a member of the board of directors of the Canadian Physiotherapy Association for the past five years, and I bring to you a position paper that was developed in 1997. I was given the task of chairing a national committee for the Physiotherapy Association to look specifically at manipulation and its practice in our profession, and I believe this might be important for you to have this information from a national association perspective.

The national Physiotherapy Association is a voluntary association for physiotherapists in Canada. It currently represents over 9,000 physiotherapists across the country, and its mandate is in the areas of ensuring excellence in the education of physiotherapists, in the clinical practice of physiotherapists and in the body of research relating to physiotherapy education and practice. This position paper on manipulation was undertaken over about a 14-month period where we looked at current case law in the United States, in Canada, in Europe, Australia, New Zealand and Britain. We looked at the education of physiotherapists, and the position paper speaks for itself.

The position of the Canadian Physiotherapy Association is that manipulation is one of the shared aspects of scopes of practice which is current in the health care system today, that many professions share aspects of scopes of practice. The position of the Canadian Physiotherapy Association is that this is the best system, and manipulation, spinal or peripheral, falls into this category. Thank you.

Mr. Chairperson: Thank you very much for your presentation. Are there questions of Ms. Morrow? If not, thank you. Then we will move on to our next presenter, Kelly Robert Milan. Do you have copies of your presentation for handouts?

Mr. Kelly Robert Milan (Private Citizen): Yes.

Mr. Chairperson: Thank you. Please proceed, Mr. Milan.

Mr. Milan: Good evening, again, I will be brief as many of these topics have been thoroughly covered. I come to you this evening as a private practice physiotherapist in Winnipeg and also a private clinic owner as well. I graduated in physiotherapy in 1991 here at the University of Manitoba. I have a few points I think I might be able to add to some of these issues just from sort of a physiotherapist's ground-level perspective.

My first point that I want to make is that we have had a lot of discussion tonight about direct access but basically we do have a direct access system right now. The proposed legislation is simply a refining of that and perhaps a streamlining, so it is a matter of degree. Right now we have what is defined as direct access, but this will be refined somewhat.

Physiotherapists can currently assess a patient, but we must communicate with the patient's physician regarding a treatment program. This will not change with the proposed legislation. It is unethical and unprofessional not to communicate with any of the members of the health care team. Physiotherapists have always had a close working relationship with doctors and other health care providers, and this will certainly not change in the future.

The proposed legislation will allow easier access to physiotherapist services, particularly in rural areas as well, and it will contribute to reducing duplicate visits to other health care practitioners as well. So there are some benefits to the health care system in Manitoba.

I would like to touch on the example that was brought up earlier about little Johnny with the sprained ankle coming into the private clinic. For example, if I were to see this patient right off the street, yes, I would take a full history and fully assess the patient, but in all likelihood and I am almost sure, even without seeing the patient, I would be directly communicating with the physician for their evaluation as well. But there are cases where, for example, a patient with back pain that we have seen three or four times during the same year, it may not always be necessary to have the physician involved right away. So there are some advantages to the way this new legislation will work and streamline things.

* (2130)

Physiotherapists–my next point–have an excellent safety track record, and I have some direct involvement with this. I served as the investigations chairperson for the Association of Physiotherapists of Manitoba from 1994 to '98. During that time frame, there were no complaints regarding harm done by a physiotherapist using any form of hands-on treatment. That includes spinal manipulation as well, but it also includes all of the other procedures that we do when we place our hands on a patient, massage, different mobilizations, we call them, which are less of a degree of a manipulation, let us just say. Prior to my term, I am almost 100 percent positive there have never been any complaints regarding manipulation by a physiotherapist in Manitoba.

The physiotherapy profession already has formal high standards for spinal manipulation, and that has been covered tonight, but, from a personal perspective, I do not practise spinal manipulation, because I am not confident to perform it. I know that the risk is obviously higher to the patient, and I would not attempt it. I do practise manipulation in the joints of the extremities like the hands and feet, for example, but not in the spine, the neck, or back. It is my professional judgment not to perform it, and I am fully accountable for my actions should I attempt it, not only through actions from the patient but also from our regulatory body, which will in turn be the college of physiotherapists, but I am subject to a very rigorous disciplinary process should there be any problems. And I should add that this process will be very accessible by the public. Currently it is, in my view, very accessible, but the whole process is very streamlined with our new legislation.

I just would like to mention too that since practising since 1991, I have not pursued this goal that I still have of practising spinal manipulation, because I believe it can help a lot of people. I have not pursued it because it involves a very significant time commitment and a lot of effort as well and a rigorous examination process. It is a goal for the future, but it is a very lengthy process that I would have to go through to at least be competent at performing spinal manipulation.

I would like to make the point too that within the Canadian Physiotherapy Association, which is responsible for examining physiotherapists who want to perform manipulation, there are also physicians that sit on those evaluation committees examining physiotherapists as well. It is not just physiotherapists examining physiotherapists.

I have not, but physiotherapists in this province have performed spinal manipulation for decades without incident under our current act.

The malpractice issue, just briefly, as a private practice owner, all of my physiotherapists are required to have maximum malpractice liability insurance. I believe it is around $5 million per year, but certainly those types of details, I know as a profession we are open to recommendations from government, and so on. Currently I am fully accountable for all my actions, and this will not change in the future.

Just speaking to the issue of determining a physiotherapy diagnosis before initiating physiotherapy treatment, this has been in practice for decades, and that has been talked about at length, but just in my career I have referred many patients back to the physician with suspicions of nonphysiotherapy type problems, and vice versa. Physicians have advised me, quite correctly they have advised me on various physiotherapy treatment specifics that I have wanted to perform. They have been correct in that grounds too, so there is also a lot of two-way advice that goes back and forth.

The last point I think has been addressed well, but physical therapy, just in case there is a little bit of confusion still on this issue, the term physical therapy is the official term for the profession in the United States. Physiotherapy is the title in many other countries including the United Kingdom, but in Canada the two titles are both used officially. That is why in our new proposed legislation we wanted to include both terms. There is some misinterpretation that physical therapy is a term used for a specific type of treatment, for example, cold treatment or ultrasound or whatever, but that is incorrect. It is the title for the profession as a whole.

That is my presentation. Thank you for your attention.

Mr. Chairperson: Thank you very much for your presentation. Are there any questions? No? Thank you.

I would just like to note for the sake of the record that there are two presentations that would be added to Dr. Stewart's presentation that the page handed out. That is for the record.

We will then move on to Marc Garrett, please, and Marc Arbez, please. Please proceed, Mr. Arbez.

Mr. Marc Arbez (Private Citizen): First of all, this could be fairly brief. I am not a physiotherapist. I am an engineer and I am also an artist. Just to set the record straight, I do not know anything about Bill 26 or about physiotherapy, so do not ask me any tough questions about it.

I just want to relate to you a couple of really positive experiences I have had with physiotherapy in the recent past. The first happened about two and a half years ago when I woke up with an extremely sore neck. I did not know what was going on, so I decided to go directly to a physiotherapist that I am aware of. He assessed the situation and referred me on to a physician. The physician referred me on to a neurologist. I had a CAT scan done on my neck, and it was assessed as a herniated disc, so I really appreciated the fact that this physiotherapist was aware of which way to point me and where to direct me. As a result, I am convinced that it helped me in the healing process over the last few years. If I keep going with my injuries, you are going to think that I am kind of a $6-million man here.

The next one that happened–there have been a few–but the more recent one that I have of note here is that recently I have been training for the Manitoba Marathon. I am not a great runner by any stretch of the imagination, but it was my first attempt at the full marathon. I have been training for about two or three months and getting fairly proficient at it, in my own books. As it turned out, I developed a real sore foot within two weeks of the marathon. I thought, you know, I will have to go in next year because I did not think that I could handle it. I had been running 20, 25 kilometres without any problems, and after that injury, I could not even run 2.5 kilometres without pain, and I knew I had to drop out. So I decided last minute to consult this same physiotherapist. So I went directly to him; he assessed it, manipulated it and it gets into terminology that I do not understand here, but it is something to do with cuboid syndrome. It sounds like a disease, something an artist would have. Anyway, he treated it with ultrasound and told me a few things to do on my own for manipulation for the soreness. As it turned out, I ended up running the full marathon, which to me was very important. To people who have not seen my running style and think that I might be good at it, I tell them that I ran it in under four hours, but for other people who are aware of my kind of unorthodox style, I ran it in over four hours.

So, anyway, that is all I needed to tell you about my positive experiences with physiotherapy.

Mr. Chairperson: Thank you very much for your presentation. Are there any questions? If not, thank you very much.

We will move on to our next presenter. Murray MacHutchon, please. Do you have copies for handout? No. Okay, please then proceed, Mr. MacHutchon.

Mr. Murray MacHutchon (Private Citizen): Mr. Chairman and members. Unlike other members, I am not pleased to be here. I am sorry that you had to go through this this evening. I think it reminds me of that saying that he who slings mud, loses ground. I am sad that we all have to be here with misinformation and try to clear up that information. I am a very proud physiotherapist and a very proud manipulator. I am very proud to serve Manitobans, proud to bring them health. I am also very proud that I do not manipulate a thousand times a week.

I think the thing that I did want to say and Dr. Stewart forgot to mention to you is that physiotherapists are better, physiotherapists are much safer, physiotherapists are more specific,

and physiotherapists are more selective. The reason that we are better is that we push each other to be better. We as physiotherapists believe in evidence-based practice, research. That research and evidence-based practice comes out of the well-grounded doctors that Dr. Brown is involved with, medical research, science, chiropractic literature, physiotherapy literature, osteopath literature. We try to make ourselves better by looking at the science and the research. We use manipulation safely. It is planned; it is effective. There should not be a gatekeeper to it. I do not agree with the amendments that were put before this committee.

In short, I want to say that to be effective and safe to Manitobans, we as professionals, both doctors, physiotherapists and chiropractors have to share information and do more in the research area to continually treat the public and become safer practitioners to Manitobans.

* (2140)

Mr. Chairperson: Thank you very much for your presentation. Are there any questions? If not, thank you again.

We will proceed to our next presenter. Evelyn Lightly. Do you have copies for handout?

Ms. Evelyn Lightly (Private Citizen): Just point form? Do you want them?

Mr. Chairperson: Okay. Thank you. Then proceed, please, Ms. Lightly.

Ms. Lightly: Again, thank you for this opportunity to speak. Most of what I have to say has already been said, so I will not repeat. I would just like to tie it together with a few thoughts and concerns.

I graduated in 1983 and have taken a number of postgraduate courses in orthopedics, and I have been qualified as a manipulative therapist since 1990. In the past nine years, I have taught some of those postgraduate courses in Manitoba. My concerns are regarding the suggested changes to the act as they deal with changes in our curriculum and educational process being dictated to meet the standards outside of our recognized profession with possible encroachment on our area of accepted expertise.

The process of the education in manipulation has been gone over. as well as, our undergraduate program. Our undergraduate program does involve a close alliance with the medical profession and follows a medical model of management and patient care. This medical model is taught to us by many of the same educators who teach medical students. Because of this close association in education and workplace settings and a generally unified approach to treatment and management of our patients' medical rehabilitation, we have the full support of the opening of our act from the College of Physicians and Surgeons, as well as, other allied health professionals.

One should consider if this full support and confidence in our profession would change if we were to have our skills, competency and knowledge examined and accredited by an outside body, one with quite a different training and approach to management of physical dysfunction. To have our education, both theory and practice. judged and mandated by the Chiropractic Association is unnecessary and intrusive when we already have met provincial and national standards.

The ability for qualified physiotherapists to manipulate has been part of our act for many years. I realize and respect that health practitioners are trained and choose to specialize in the act of manipulations, many of them certified athletic therapists, et cetera, have been mentioned. Many of these groups are not licensed by any governing body, thus not watched over and scrutinized by any authority or peers. The fact that we have a governing and licensing body overseeing our profession, our responsibilities and our actions proves our responsibility to our patients. The fact that there has yet to be a complaint to our organization regarding manipulation is a testament to our level of competence as manipulators.

Just briefly mentioning the other concern in terms of malpractice insurance, the MCA does suggest the enforcement of malpractice insurance to protect our patients. Being pro-

active, our association had already proposed this change to our act. Up until now, it had been a personal choice of members not mandated or ordered by law. As a clinic owner in private practice, I, too, can comfortably state that most, if not all, private practice members have such insurance, and it is a professional decision and one of personal choice.

However, what I would like to bring to everyone's attention in this room, having malpractice insurance does not make a practitioner more qualified, skilled or knowledgeable. It does not promise the delivery of the best available treatment, nor does it decrease the risk of any treatment–not just manipulation, spine or extremities. Malpractice insurance allows financial assistance for the practitioner after a complaint has been made after an injury has occurred. A patient's safety is not dependent on our purchase of malpractice insurance, mandatory or otherwise. In our hands, their safety is dependent on our knowledge, skill and safe and effective delivery of manipulative therapy. It is with a proper and detailed assessment, thorough and specific testing, and competent and precise use of technique that the protection of all patients is ensured. We as a profession believe Manitobans are receiving that from physiotherapists. Thank you.

Mr. Chairperson: Thank you very much for your presentation. Are there any questions? If not, thank you again. We will move on to our next presenter, Ruth Barclay-Gordon.

Floor Comment: She had to leave.

Mr. Chairperson: Okay. The next, Brenda McKechnie. Please proceed, Ms. McKechnie.

Ms. Brenda McKechnie (Association of Physiotherapists of Manitoba): On behalf of the Association of Physiotherapists of Manitoba, the regulatory board for the practice of physiotherapy in Manitoba, I would like to thank the committee for the opportunity to make a presentation regarding Bill 26, The Physiotherapists Act. My name is Brenda McKechnie, and I have served as the registrar, executive-director of the Association of Physiotherapists of Manitoba for the past 10 years, and I, too, am a physiotherapist.

The current Physiotherapists Act was proclaimed in 1981. With the changing health care climate and a number of problems identified with the current act, the Association of Physiotherapists of Manitoba determined that it was time to update our legislation. As part of the process, we sent out 60 copies of the draft act in December of 1998 to various stakeholders and other interested parties. About 20 written responses or telephone calls were received. I have included in the appendix of my written submission copies of letters received from the College of Physicians and Surgeons of Manitoba, the Manitoba Association of Registered Nurses, the Faculty of Medicine at the University of Manitoba, and others who are fully supportive of the changes proposed in the new physiotherapy legislation.

The provincial governments in Ontario, British Columbia and Alberta have dealt extensively in the past few years into the scope of practice of various health care professions as umbrella health legislation has been enacted in some form or other in those provinces. For the profession of physiotherapy, the inclusion of manipulation within the scope of practice has been examined by each of these provincial governments. It has been determined by these governments that physiotherapists are trained with the skills, knowledge and abilities to carry out manipulation. The other remaining provinces have separate legislation governing physiotherapy, and each of these acts include manipulation or manual therapy within the physiotherapy scope of practice. In regard to an earlier question about whether there was direct access in other provinces, I have included a chart there and it is in there, as well.

Practice standards regarding manipulation have been set by the physiotherapy profession. These standards are currently under review by the College of Physical Therapists of Alberta who have undertaken a project to determine the competencies required by physiotherapists who practise manipulation. The project is being partially funded by the Association of Physiotherapists of Manitoba and should be completed later this summer. So clearly we are going to be buying into this process if we are going to be funding it.

One of the goals of this project is to achieve national validation of the manipulation competencies by the profession. The chiropractic profession has been invited to provide input as well. The physiotherapy profession has been setting and reviewing its own standards for a very long time and without direction from any other profession. These standards have been of high calibre to ensure that quality physiotherapy care is provided to the public.

In regard to one of the statements that was made earlier, I would just like to point out that physiotherapists would never be allowed to practise 1,000 manipulations a month. That would be considered very excessive for our profession.

The physiotherapy profession continues to take a leadership role in many areas of health care, including the establishment of prior learning assessment and recognition or PLAR programs for credentialing of physiotherapists and their competencies. There is a national entry level examination that includes multiple choice questions as well as a clinical component, and has been shown to be a valid and reliable tool, and is competency based.

* (2150)

There was a joint project undertaken in 1996 with the Federation of State Boards of Physical Therapy in the U.S.A. and our counterpart in Canada, the alliance of physiotherapy regulators, to examine similarities and differences in physical therapy practice between the two countries. While there are some similarities, reference in the U.S. literature to similarities or problems with practice in the U.S., there are a lot more differences between practice in Canada and the United States. We have also undertaken an entry level competency manual which sets out entry level competencies required for people entering or re-entering the profession.

Physiotherapists in Manitoba have been practising safe manipulations as evidenced by a lack of any complaint or lawsuit against physiotherapists in Manitoba. You have heard that a few times. In a study undertaken by the law firm of Smith Lyons in Ontario in 1997, there was no evidence of any civil cases or criminal cases against a physiotherapist in Canada for the practice of spinal manipulation. While the current Physiotherapists Act does not contain a provision for compulsory malpractice insurance, physiotherapists working in situations where there is no employer coverage have responsibly and professionally proceeded to purchase malpractice insurance for themselves without any legal requirement. The Canadian Physiotherapy Association has, for many years, provided members with the ability to purchase malpractice insurance. However, the new act will require compulsory purchase of malpractice insurance.

It should also be noted that we currently have a code of ethics that exists in our legislation, and it requires physiotherapists to practise in the areas of their competency. Within the current Physiotherapists Act, patients are able to gain access to physiotherapy services without a physician's referral. Direct access to physiotherapy treatment has been available to the public since 1981, and physiotherapists have therefore been primary health care providers for the past 18 years. The current act stipulates a physiotherapist must be in communication with the patient's physician or in consultation with the patient's physician. These two clauses have become problematic for physicians as well as physiotherapists.

Last year, APM worked in collaboration with the College of Physicians and Surgeons of Manitoba, as Dr. Brown alluded to, to redefine the communication and consultation wording. However, both parties would like to see this wording removed from the new act. The changing health care climate with the focus on community care and the shortage of physicians and physiotherapists in Manitoba are factors which have precipitated the need for this change. With the length of time it takes to get an appointment with a physician, and then the length of time it takes to receive physiotherapy treatment, we see the removal of consultation and communication as a benefit to the Manitoba public from the view of timeliness and cost-effectiveness.

The College of Physicians and Surgeons recognizes that this is not an attempt to circumvent our professional relationship with

physicians. Physiotherapists have been and will always be closely linked with the medical profession. We practise within the same scientific medical model, undertake research with the medical profession, and work in a collegial manner alongside, not under but alongside, medical physicians.

The new legislation will allow the physiotherapy regulatory board in Manitoba to achieve compliance with the other physiotherapy regulatory boards across Canada for the purposes of the agreement on internal trade. There are only a couple of areas in which we currently are not compliant, but the provisions of Bill 26 will allow us to be consistent with the other provinces concerning labour mobility.

I have just recently returned from an AIT meeting in Toronto. It was attended by representatives of the federal government, and from that I am aware of the urgency in passing Bill 26 if we are to meet our obligations to AIT by the year 2001.

The Association of Physiotherapists of Manitoba is committed to our mandate of public safety and protection. We feel that Bill 26 will allow us to be more proactive, not reactive but proactive, in this role. Mandatory continuing competency programs will be established. The manipulation competencies currently being reviewed in Alberta will be included, and the college will have provision to undertake practice audits. There will be a variety of options to deal with complaints and discipline, including requiring members to upgrade. Malpractice insurance coverage will be mandatory.

This is a good piece of legislation. It is responsive to the changing health care climate, and it offers opportunities for reducing health care cost. It allows the college to be proactive in fulfilling its mandate of protecting the public, and I urge you to pass Bill 26 without further amendment and before this legislative session ends.

I just wanted to address a few of the points that were made earlier. They are not in my presentation, but they just came up. Right now manipulation is being taught at the undergraduate level at the school of med rehab, University of Manitoba. During that program of learning about manipulation, they do not make a distinction between spinal or extremity manipulation. So, to separate that out in our legislation, would not be appropriate, we do not feel.

Also, in regard to informed consent, I would just like to say that is a standard procedure with physiotherapists. Every patient is informed of what their treatment is going to be, and they do have the ability to approve or disapprove, to walk out of the clinic if they would like. We do not treat 1,000 patients a month, so we have the time to actually explain to the patient what they are about to receive and give them those choices.

Thank you very much for listening, and I would be pleased to answer any of your questions.

Mr. Chairperson: Thank you for your presentation.

Mr. Stefanson: Thank you, Ms. McKechnie, for your presentation. I just have one question. You say it twice in your presentation in no uncertain terms on page 2 of the second last paragraph, the last sentence. You say: however, the new act will require compulsory purchase of malpractice insurance; and, in the second last paragraph of your presentation you go on to say: malpractice insurance coverage will be mandatory. I take it that is the position of the association to deal with that issue in that fashion through the regulations that we discussed at length here this evening.

Ms. McKechnie: Yes, our board discussed this issue prior to even drafting up any of the legislation because it is also a commonly accepted provision in other legislation across the country. We felt that we would get on board with that as well. So it was provided for long before we even drafted anything up.

Mr. Chomiak: Thank you for the presentation. You made reference to the inclusion of the Alberta competencies within Manitoba. Could you just briefly elaborate on that for me? Is it the intention of APM–interesting initials, it goes back in history in the Legislature for some time–to include the Alberta competency levels within

the regulation? Is that what you said or is it something else?

Ms. McKechnie: Yes, that competency project was initiated because when the Alberta legislation came through for health professions, the college in Alberta wanted to ensure that the physiotherapists that were practising manipulation before the act came in would still be competent to practise it after given the new provisions of the act. So they undertook this project. What they did in the project was ask for representation from across the country. We sent delegates to weekend focus groups, and we provided input into those competencies. So our intention is with having sent members to it, having written about it and partially funding it, that we have a stake in it and that we would be using those.

Mr. Kowalski: Thank you for your presentation. I notice in the attachments here you included the letters you received after sending out the draft legislation, and one of them is from the Manitoba Association of Registered Nurses. I notice that they made some recommendations. One looks like it has been included in the legislation to change Part 4, Section 27(2). It has been renumbered from the term "evidence" instead of the word "records," and I notice that has been there. But the other recommendation that they made is that public representative does not exclude other regulated health care providers from being named to the council. They recommend that the wording be changed to be similar to their act and that they found people who are not members of the other health-regulated health professions bring a special perspective to there. Now do you agree with the Manitoba Association of Registered Nurses' recommendation?

Ms. McKechnie: We looked at that very closely, and in talking with Manitoba Health we did end up excluding physiotherapy members past or present from being public members. We also are very cognizant of the fact that there is going to be a huge retirement in all the medical professions that is up and coming. Some of these members who could possibly be a public representative could be people who have retired for a considerable length of time and have lost touch completely with their profession. We were not sure that was really fair to exclude them, but they also have an interest in health care, so that is where we worked out the wording on that one. Okay.

Mr. Chairperson: Thank you very much for your presentation. We will move onto our next presenter, please. Dennis Desautels, please. Do you have copies for distribution?

Mr. Dennis Desautels (Private Citizen): No, I do not. I am sorry.

Mr. Chairperson: Okay, please then proceed, Mr. Desautels.

* (2200)

Mr. Desautels: I thank the committee for listening to me. My intent was to come and listen and not to speak, but as my colleagues know, I have a hard time doing that. I have sat here and listened. I have been past president of the Canadian Physiotherapists Association of Manitoba. I have been chairman of APM on two occasions. I have been a board of director of our national association on two occasions. I have been chairman of the private practice division, Canadian. I have been a member of the orthopedic division when it developed the standards for practise manipulation and of sports medicine division. If you are impressed, do not be. It just means I do not know how to say no.

I just want to talk to you about a practical point of view of this legislation. I am an owner of seven clinics in this province. I first opened up the clinic in 1983 because the legislation in '81 allowed me to treat Manitobans the way I thought they should be treated, in other words, to go to a practitioner of their choice to get the service they wanted. Prior to that I worked in the Health Sciences Centre for six years and felt constrained by the regulations of a hospital.

The act has allowed me, when I first started, with only 10 percent of my patient population coming in without a referral. Over the past years, with the diminishing practice of the physicians, with the closing down of their caseloads, with numerous other things, patients are now coming to our door in greater numbers. My caseloads now probably push 30 percent,

patients coming in without a referral. If the legislation was to change and take that little component away from me, you are looking at 30 percent of my income, you are looking at 30 percent of taxes–we all know taxes–would be the effect on my well-being and my therapists.

Two of my clinics are in rural areas. Rural areas have a hard time getting physicians to see them. More patients are going to a physiotherapist to see them because they cannot get in to see their doctors. All my therapists carry malpractice insurance–I do not know why this is such an issue–$5 million max. They have to carry it, otherwise they do not work in my practice. I would bet I could go to every private practice in the province and they would tell you the same thing, that all their members must carry malpractice insurance because they do not have a hospital to bail them out if they do not have it. We all know hospitals may not do that.

Standards of practice. My clinic was the first one accredited in Canada under the same standards that are given the physiotherapy departments in hospitals. We undertook that project, and now you have physiotherapy practices across Canada being accredited by a national association.

Manipulation. Yes, I do it. I have taken my levels. I have not passed; I have not taken my exams because I chose not to. I will do a number of manipulations I feel confident with. I will not touch any of the ones I do not. Any of the ones I do not, I have a strong referral base with other physiotherapists and with other chiropractors. What strikes me as funny about this issue is that I work closely with chiropractors, and some of them are embarrassed about the stance that the MCA has taken because we work closely together with each other.

This current legislation we have prevents me from taking referrals from them. I have to check with the physician first, send that patient to a doctor, he has to get an extra visit, it costs money, it comes back to my clinic and so on. They would like us to have direct access so we could flow patients back and forth to each other. So, in a sense, in a practical point of view, this is probably the best legislation that Manitobans can have. It is going to give them access to physiotherapists; it is going to get physiotherapists working closely with chiropractors. Physios already work closely with doctors in situations in our clinic. We have diagnosed four cases of cancer. We had to refer those patients on to the physician. The physician had to do further tests. We act as check mechanisms for each other. We cannot prescribe medication. We have to work closely with them. So by changing this legislation to give us more direct access, it certainly allows the population of Manitoba much better care in terms of health care.

I am a little bit of a dreamer. You see, I would like to see the day where a physiotherapist could sit inside an emergency department, and instead of having a doctor look at all the sprained necks, backs, knees, fractures coming in, a physio could assess them and say, yes, maybe you should go here, maybe you should go there, and free that doctor up for the more important critical things like strokes or heart attacks and this and that.

So that is what I would like to see in terms of this legislation. I think this legislation will allow us the opportunity to do it. So whatever you do, do not change the legislation. It is a good piece of legislation. It has increased the standards in complaints investigation. It has allowed us to discipline our members a lot of better. So, whatever you do, keep it the way it is. Pass it as quickly as you can.

Mr. Chairperson: Thank you for your presentation. Are there any questions? If not, thank you very much.

We will move on to our next presenter, a walk-in who just came up, Madeline Arbez, please. Do you have a presentation?

Ms. Madeline Arbez (Manitoba Chiropractors' Association): No, I do not. I will be very brief, realizing the time and the issues at hand. I am Madeline Arbez. I am a Manitoba citizen, a mother of two, and the executive director of the Manitoba Chiropractors' Association. I come to you as one of the few nonmedical individuals speaking to you tonight. I guess from my business background, I was trained to always

keep things very simple, focused, and to bring back home the points.

Many of the issues raised tonight are in fact compatible to what the chiropractic association is bringing forward. There are in fact two points: malpractice insurance, which has been addressed, and the issue of spinal manipulation and the ambiguity of the act as it stands.

The issue tonight on malpractice insurance is in fact correctly stated: the doctors of chiropractic are not stating that malpractice insurance will compensate for proper protocol standards, et cetera. It will not be in place in order to compensate for something that should be there in terms of standards competencies. It is simply a protection mechanism that should be there in case of. We would all like to believe that we can keep the sterling record that we all have at one point, but it is probably very responsible to have these mechanisms in place to ensure that in case it does happen, it is there.

Spinal manipulation. I am not a doctor of chiropractic, I am MBA, so I will address this very simply. The position was it is a specialization. Numerous studies, more than we could possibly discuss at this point, have been published. Many are debatable, and as many experts confirmed tonight, statistics may say many things, and results are often subject to the interpretation of the parties presenting the issues. We have no difficulty sitting down and discussing the issues at hand and the factual information.

We conducted a survey when I first started with the Chiropractors' Association which was a Manitoba market-wide study. The question in the study, and I do not have the results here, but I will give you a general overview, was: what would your perception be if the provincial government legitimizes certain health care coverage or provides you direct access via legislation? The response was in majority that people perceived legitimization of a certain service to be an indication of safety, of a meeting of standards, and of a fact that these checks and balances have been in fact reviewed by the people in power and charged with that responsibility. That is in fact the position that was taken forward to the board when we reviewed this.

Let us not forget the chiropractic association was asked to come forward with their comments. Their comments may not have been as quickly as they should have been, but they were brought in with a constructive objective and in light of their position as health care practitioners. The MCA raises all the issues and has in fact stated, and you have it in writing, that they look forward to working with the physiotherapists. They look forward to a collaborative effort. We simply want to bring these points forward for everyone to stop and think. The point is not to stop the legislation. The point is to simply reflect on everything being presented. because the opinions are vast and varied.

* (2210)

Finally, just a couple of statistical clarifications. Dr. Stewart is not the, I guess, bionic chiropractor. He does not see a thousand patients a week. He actually sees 250 patients a week on average, and again those who understand statistics will understand the mean and the laws of the lower and higher in average, but he sees on average 250 patients who would require possibly four different techniques, and they are there to see him because they require this specialized service. So, therefore, he is not seeing a thousand people in a week. If he did, we would certainly hear about it.

Finally, I would like to thank you all and thank everyone who presented. It was certainly enlightening for me as a citizen and gives me comfort to know that legislation is being reviewed at some shape or form in a public context. Thank you.

Mr. Chairperson: Thank you very much for your presentation. Are there any questions? If not, thank you. That brings us to the bottom of the list for Bill 26. Are there any other presenters here tonight on Bill 26?

Bill 36–The Registered Nurses Act

Mr. Chairperson: We will move on to Bill 36, and I would like to call on Sue Neilson, please. Sue Neilson. Do you have a handout?

Ms. Sue Neilson (Manitoba Association of Registered Nurses): I will make this very short.

Mr. Chairperson: Okay. Thank you. Please proceed, Ms. Neilson.

Ms. Neilson: Good evening. As executive director of the Manitoba Association of Registered Nurses, I am presenting on behalf of Sharon Tschikota, the president of the association, who, regrettably, is out of the province, and also the MARN board of directors. Thank you very much for the opportunity to speak in favour of Bill 36, The Registered Nurses Act.

Though the current Registered Nurses Act has served us well in the past, it is out of step with today's health care needs and expectations. The proposed legislation was developed through a comprehensive consultation process involving employers, registered nurses, public representatives and other regulatory bodies and colleagues such as the College of Physicians and Surgeons, the Manitoba Association of Licensed Practical Nurses, the Manitoba Association of Registered Psychiatric Nurses, the Manitoba Pharmaceutical Association, the Physiotherapists Association and Manitoba Health.

The consultation process included open forums throughout the province: Winnipeg, Brandon, Churchill, Thompson, Dauphin, Flin Flon and The Pas. We believe regulation of health care providers will best serve the public interest by legislation which addresses the following six principles. First, accessible health care calls for flexible scopes of practice; (2) health care providers function within their demonstrated competence; (3) improved accountability through increased public representation and disclosure of specific information about members, so the consumers can make informed choices about their care; (4) effective continuing competence assessments and professional discipline processes and an ongoing evaluation of the effectiveness of these processes in protecting the public; (5) facilitating professional and geographical mobility of competent health care providers; (6) encouraging a flexible, rational and cost-effective system that allows effective working relationships amongst health care providers.

The Manitoba Association of Registered Nurses board of directors is strongly of the view that the new legislation is a good piece of legislation. It will serve the public and the profession well. The legislation is progressive, forward-thinking, transparent, and demonstrates a high degree of accountability to the people of Manitoba. Thank you.

Mr. Chairperson: Thank you for your presentation. A few questions.

Hon. Eric Stefanson (Minister of Health): Ms. Neilson, thank you very much for your comments and thank you to the Manitoba Association of Registered Nurses for their very extensive input into these legislative changes. I really just had one general question that maybe you could comment on, the fact that this legislation will also provide a mechanism for recognizing advanced nursing in our province, and maybe you could just add a few comments on the importance of that aspect.

Ms. Neilson: Thank you very much. In consultation with a number of employers, and certainly with registered nurses in the province in trying to meet the various needs of communities throughout the province, they are finding that the current scope of practice of registered nurses is indeed not meeting the needs of many of the communities and the public. As most of you are aware, we have communities in northern Manitoba specifically that engage a number of registered nurses who are functioning in a scope of practice that is broader than the traditional scope of practice. We also have a number of nurses working in community care centres, even at Health Sciences Centre.

Currently, the processes that we use in order to provide competent care is working relationships with the College of Physicians and Surgeons and the Pharmaceutical Association, so that indeed by establishing protocols, establishing the educational requirements, we are still able to provide competent practice. The new Registered Nurses Act and the provisions within there apply for a mechanism whereby we still are able to work with our colleagues in articulating the competences that are necessary, the education that is necessary. Also, we have the ability to establish the individuals on a

particular roster, so that when the public phones up and says, can so and so do this that and the other thing, we can give that information to the public very, very quickly. With the continuing competence monitoring mechanism that the act provides for, it again will ensure that the public is receiving competent care by any practitioners that are registered.

Mr. Dave Chomiak (Kildonan): I want to thank you for the presentation. I also want to thank MARN for also providing our caucus with briefings on the act. I think that has been a pattern that has been established, and I think it is very useful, particularly in legislation of this kind.

I want to ask you as executive director of MARN whether you are aware of the amendments to The Medical Amendment Act amendments that are before us today?

Ms. Neilson: Yes, we are. In fact, there is a meeting tomorrow with the College of Physicians and Surgeons, where MARN will be working with them in trying to come up with some collaborative mechanism that will work for the people of Manitoba.

Mr. Chomiak: I thank you for that. I wonder if you might aid this committee, because at this committee today we are going to be dealing with the clause-by-clause issues relating to The Medical Amendment Act, and one of the issues of significance with respect to that act concerns the setting up of a registry of physician assistants under that act. I am not certain how that relates to the advanced practice nurses' registrar that is being set up by MARN and the relationship between the two.

I wonder if you might give me, albeit you may not have had a chance to examine it, but I would like a perspective from MARN. Again, I do not want to put you in a difficult position of necessarily representing MARN, but we are going to be dealing with this legislation tonight, and I would appreciate your input and advice in that area, and that is the fact that there is a provision in the act under Part II, I believe, that deals with the issue of physician assistants. I wonder if you might comment on that.

Ms. Neilson: You are quite right. As I said, my president is out of town. I just returned to the province last night, and my secretary informed me that I was going to this meeting tomorrow.

That being aside, last summer, through Manitoba Health, the College of Physicians and Surgeons and the Manitoba Association of Registered Nurses, along with the University of Manitoba, as a number of stakeholders we collaboratively visited a unit in North Dakota to look at exactly what kinds of different practice models there were in order to meet the needs of various communities and various population groups. So we started a consultation and collaborative opportunities well over a year ago.

What we are looking at from a regulatory body point of view, and certainly Mr. Chomiak, I am aware, is quite familiar with The Medical Act, as the rest of the legislative members are, but both, in fact all pieces of legislation are looking at continuing competence and being able to use registers that will clearly be able to articulate who can do what in what situations and under what circumstances.

Certainly in The Registered Nurses Act that is being proposed, not only will the educational preparation but also the continuing competence will be one of those mechanisms that someone will have to undertake in order to demonstrate. With the College of Physicians and Surgeons. we have worked on a number of different processes in the past. Certainly, we have collaborated on registered nurses doing what is traditionally been done by physicians in the past. As I say, my example has been in health sciences in the North, and I am anticipating that we are going to be able to again find a mechanism whereby the public's needs are going to be met by a competent practitioner.

Mr. Chomiak: Thank you for that response. Of course, it is perhaps a little difficult for you to respond, and I will be posing these questions to the appropriate official from the College of Physicians and Surgeons. Do you foresee nurses participating as a medical assistant under the amendments to The Medical Act, question (a), and, question (b), do you see the provisions of an advanced practice nurse being in any way in conflict with the role of a physician's assistant?

* (2220)

Ms. Neilson: You are quite right. I have not looked at the piece of legislation, so I am going to give you a broad-based principle.

Certainly as a registered nurse, should they wish to take an opportunity of having a title physician assistant, as long as they function as a registered nurse, they will be in accordance with The Registered Nurses Act. Therefore the competence, knowledge, skill, judgment, they will have to be accountable to The Registered Nurses Act.

The advanced practice nurses, currently we have them in the system now. They work collaboratively with physicians; they work collaboratively with other health care providers, and there is not a conflict.

Mr. Chairperson: Any further questions?

Mr. Kevin Lamoureux (Inkster): Mr. Chairperson, I must compliment Ms. Neilson. She articulates so well. Having had the opportunity to meet with her to have some dialogue about registered nurses and express concerns, even though we do not necessarily agree on every point, I do very much appreciate the input that you have had to this particular piece of legislation in which we, too, do not see any problems in terms of passing.

But one of the issues that I had brought up was, given the nursing shortage in the province of Manitoba, the Minister of Health and I believe others are sympathetic to the need to get recognition of credentials of individuals who have practised as nurses abroad. As the executive director, do you see that this is something which can be done in the short term to help facilitate that need that Manitoba has today?

Ms. Neilson: Again, one wonders whether luck just enters. We actually had a meeting, myself and my colleagues, the Manitoba Association of Licensed Practical Nurses and the Manitoba Registered Psychiatric Nurses Association, with Manitoba Health just today, and, again, it was with the mechanism of how indeed can we look at graduates from foreign countries, not from the vantage point of compromising the standards that have been set by Manitoba, but how, in fact, can we facilitate the assessment of those particular graduates, providing them with the learning opportunities where there may be gaps in order to expedite the process. We have met with individuals from Manitoba Health and from Education. So we are trying as best as one can in looking at some creative solutioning.

Mr. Lamoureux: I just want to express my appreciation and indicate that you articulate quite well on the spot, and your briefing was very much appreciated. Thank you.

Mr. Chairperson: Thank you very much for your presentation. I will canvass the room just to see if there are other presenters for Bill 36.

Seeing none, I would ask just to revert to Bill 26. Neil MacHutchon has a presentation which he has submitted, and I would just ask that we have permission to insert that into Hansard as a written submission. I believe leave has been granted. Thank you. [agreed]

Bill 37–The Licensed Practical Nurses Act

Mr. Chairperson: We will then proceed to Bill 37, and the first presenter there is Verna Holgate, please. Do you have copies for distribution?

Ms. Verna Holgate (Manitoba Association of Licensed Practical Nurses): No, I will be very brief.

Mr. Chairperson: Thank you. Please proceed, Ms. Holgate.

Ms. Holgate: On behalf of the board of directors of the Manitoba Association of Licensed Practical Nurses, we are very pleased to see this legislation move forward to second reading. I am executive director of the Licensed Practical Nurses Association. I graduated as a licensed practical nurse in 1963, and I have seen changes in the practice of LPNs through changes in the legislation.

We as an organization first introduced a need for changes to our legislation 10 years ago, and we have been working with our members as

well as our nursing colleagues and employers to see the legislative changes that we felt were necessary to ensure that changes in the practice of licensed practical nurses did occur.

One area that we felt was very important was the change in the definition of a licensed practical nurse. Under our current legislation, the legislation defines what an LPN is not, rather than what the scope of practice of licensed practical nurses is. We have found during the restructuring that this piece of legislation and the language in the legislation allowed institutions, in fact, to restrict the practice of licensed practical nurses, not based on their educational preparation but based on the language in the legislation.

We also found it essential as a profession to address things like specialization, and there are sections in the legislation that we are proposing in relation to recognizing that licensed practical nurses do expand their knowledge base in specialized areas through continuing education.

We are very pleased and have supported strongly the competency assessment program being put in place. We believe it will assist us in ensuring that our members have best practices in place through the development of such a program.

For several years, we have also identified that there were problems in relation to the areas of complaints and discipline, and we really feel strongly that the changes in the legislation are a much more effective investigation and discipline process that will serve the profession better to address concerns regarding practices.

In addition, we strongly supported increased public representation and increased public accountability sections in the legislation, and we strongly supported the organizational name change to a college of licensed practical nurses, because we strongly believe that as an organization, it reinforces to both our members and the public our role of public protection.

Mr. Chairperson: Thank you for your presentation. There are a few questions. I will call on the honourable minister first.

Hon. Eric Stefanson (Minister of Health): Thank you very much, Mr. Chairman, and, Ms. Holgate, I want to thank you, as well, and the Association of Licensed Practical Nurses for their extensive input into the changes that we have before us in this bill tonight.

I really just have, again, one general question, and you touched on it in terms of now how in the act the practice of nursing will be defined by what is done as opposed to what was in the existing legislation, and part of that really should lead to a similar question as I had for MARN in opportunities for advanced practical nursing. Maybe if you could take a minute to elaborate on that for our committee. I would appreciate that.

Ms. Holgate: We have as a profession been really concerned over a number of years that many of the programs that are in place in community colleges have restricted LPNs from taking them based upon the initials behind their names rather than on their ability to complete that education and provide that advanced nursing. So the legislation will allow us to develop areas of specialization, be able to develop standards of practice in those specialized areas and develop competencies in those areas.

* (2230)

We do know that our members practise at an advanced level through continuing education, but there was no recognition in the legislation for it, and so there was in practice settings no recognition for that advanced level of education and knowledge either, and so we very strongly support that portion of the legislation.

Mr. Dave Chomiak (Kildonan): Thank you for the presentation, and I also again want to point out and acknowledge the fact that as well you provided us with briefings on this information. What it does on matters of this kind is it allows for appropriate review and expeditious passage of legislation on matters which are essentially nonpolitical and which essentially aid all of the province. We appreciate your assistance in providing us with information on that, and that is one of the reasons why legislation of this kind has very

little difficulty passing through the Chamber. I predicted both in my speech on second reading as well as tonight that it is going to pass unanimously in the Chamber.

But I do want to ask you the same question I asked the representative from MARN. Have you been consulted, for example, on The Medical Amendment Act changes that are before us tonight?

Ms. Holgate: No, we have not been approached to date.

Mr. Chairperson: Any further questions? If not, I will again canvass the room on Bill 37. Are there any other presenters? Seeing none, I will move on to Bill 38.

Bill 38–The Registered Psychiatric Nurses Act

Mr. Chairperson: I will call on our first presenter there, Annette Osted, please. Do you have copies for distribution?

Ms. Annette Osted (Registered Psychiatric Nurses Association of Manitoba): It will be very short, Mr. Chair.

Mr. Chairperson: Thank you. Please proceed, Ms. Osted.

Ms. Osted: Good evening, gentlemen. I am pleased to be here on behalf of the board of directors of The Registered Psychiatric Nurses Association of Manitoba. I also am the executive director as were my two colleagues. Our vice-president, Marg Synyshyn, is also here this evening.

The board of directors and members of the Registered Psychiatric Nurses Association of Manitoba support the new legislation, which is before you, for the governance of the profession of psychiatric nursing in Manitoba. We are pleased to see expanded opportunities for participation by the public at large in various ways in the governing of the profession, on the board of directors, the investigation committee and in the disciplinary process.

We are especially pleased with the changes made to the peer conduct review process. The new process will enable us to better serve the public interest by providing more options at different levels of the process. The hearings will be open to the public. One-third of each of the disciplinary panels will be public representatives. There are also some significant administrative improvements to the process.

We are excited about the continuing competence program which will be established under the new legislation. It provides the opportunity to work on the prevention of negative practices rather than only dealing with them after the fact. Registered psychiatric nurses in the province have had the opportunity to comment on the principles which are in this legislation, including those which could potentially increase the membership fees paid each year. The large majority of responses we have received are in favour of the principles, though they do ask us to keep watching the budget.

We have circulated the principles of the proposed changes to various self-help groups in the mental health community and have their support for those principles.

We are pleased to be following the College of Registered Psychiatric Nursing of British Columbia, the College of Registered Psychiatric Nurses of Alberta to the college system.

I would like to take this opportunity to express my sincere appreciation to my colleagues, the executive director of the Manitoba Association of Licensed Practical Nurses, the executive director of the Manitoba Association of Registered Nurses, Legislative Counsel and all her staff for the tremendous amount of help and collaboration that we were able to get from them in the development of our legislation. We are a smaller group, have a few less resources but their generosity of time and expertise is very much appreciated. Thank you, Mr. Chair.

Mr. Chairperson: Thank you very much for your presentation. A few questions?

Hon. Eric Stefanson (Minister of Health): I, too, want to thank the Registered Psychiatric Nurses Association of Manitoba for the input

and involvement and contribution to the changes we have here tonight. I just have a similar question again. I know part of what is in the legislation is really dealing with the updating of the definition of registered psychiatric nursing, basically to reflect the more varied roles that registered psychiatric nurses perform today, and maybe you could just take a moment to touch on a few of those for the benefit of committee members.

Ms. Osted: Certainly we found that the registered psychiatric nurses who are working as community mental health workers in the province of Manitoba–75 percent of the community health worker positions are held by registered psychiatric nurses–are indeed functioning with much more autonomy than has traditionally been the case for our profession. This has been developing since 1974 when community mental health worker positions were first established and continues to expand. So we are pleased that we will have the opportunity through this new legislation to establish criteria which addresses the needs of those members.

Mr. Chairperson: Are there any further questions? Thank you very much for your presentation. Again, I will canvass the room regarding Bill 38. Are there any other presenters? Seeing none, we will move on to Bill 39.

Bill 39–The Medical Amendment Act

Mr. Chairperson: I would like to call on our first presenter, Mr. John Laplume, please. Do you have copies for distribution?

Mr. John Laplume (Manitoba Medical Association): No, I do not.

Mr. Chairperson: Please proceed, Mr. Laplume.

Mr. Laplume: Mr. Chairman and members of the committee, I will be speaking very briefly to Bill 39 on behalf of the Manitoba Medical Association, in particular with respect to Part 4, that aspect dealing with permitting physicians in Manitoba to incorporate their practices.

The province is undertaking this initiative for, I am sure, a number of reasons, but certainly with the strong encouragement of the Manitoba Medical Association process which we began well over five years ago. It is our view that allowing professionals to incorporate, in particular medical practitioners, is going to improve Manitoba's competitiveness in retaining physicians in the province of Manitoba. Most of you are probably aware that many jurisdictions already, such as British Columbia, Alberta, Nova Scotia, Yukon, P.E.I., New Brunswick, have for many years permitted physicians to incorporate. Measures are underway to effectuate that in the province of Saskatchewan and Ontario as well. In short order, it probably will be across the land, and, it will amaze you, it has long been that it is important that there be a level playing field so that Manitoba physicians will have no more and no less the same opportunities that are available to practitioners in other parts of the country. So we welcome, obviously, these proposed amendments with respect to professional incorporation. We think it is merely going to, as I say, level the playing field and place physicians in the same position that other small business people have been in for many years.

Mr. Chairperson: Thank you for your presentation. Now for a few questions.

Hon. Eric Stefanson (Minister of Health): Mr. Laplume, I just want to thank the Manitoba Medical Association for your input as it relates to medical corporations. We had some meetings a while back on the issue, and we were pleased that we were able to have that finally here in this act before us tonight. You touched on it, but I know one of the points made when we did meet about this issue was the one about the ability to retain our doctors in Manitoba, that this would just be one factor or one element that enhances our competitiveness and thereby becomes one issue that can at least play a part in helping us keep some of our doctors here in the province of Manitoba. You did touch on it. Any other comments that you would like to add?

Mr. Laplume: I agree with Mr. Stefanson that this is going to play an important role. It is not the all to end all by any means. There are a number of challenges facing Manitoba in relation to being able to compete with other provinces or the jurisdictions for medical

manpower. We think this is one part, a piece of the puzzle, if you were, but an important part.

There are other issues that need to be dealt with, and presumably it is going to take a lot of effort on the part of many people, obviously the province, the Medical Association and others, to keep working at that. It is not something which is susceptible of an easy answer overnight. Obviously, an important issue has to do with retaining our home-grown graduates and a far greater proportion of our home-grown graduates. I see allowing incorporation as assisting that measure.

When someone is graduating from Manitoba–we just had recently the family residency program members graduate at the end of June–when they are contemplating the various options that they have available to them leaving medical school with, in many cases, a very substantial debt load, they do look to opportunities under the jurisdictions, and at least Manitoba should be on a reasonable footing with those jurisdictions.

So we think this is a good step in the right direction. It is not the only step that can be taken; there are many more. But it is a positive thing. The Medical Association has had a number of disagreements with the province and probably will always have, but I think it is important not to dwell on those disagreements. You deal with those things that you can agree with, that you can fix, and you move on from there, and that is the way we see this bill.

Mr. Dave Chomiak (Kildonan): Certainly from the perspective of the opposition caucus we understand the value of the issue, particularly Part IV dealing with incorporation, from the perspective of retaining physicians in Manitoba and dealing with the issue of a level playing field, and on that basis we are supportive of the concept.

I would be interested at this time if you could perhaps enlighten us. You touched on the fact of several other issues that would contribute to retaining physicians in Manitoba. I wonder if you might elaborate for the committee today on some of the other issues that could help keep physicians here in Manitoba and attract physicians.

* (2240)

Mr. Laplume: Without getting into an exhaustive list of all things that we have proposed to government and are still in active discussions about, clearly one of the big issues that confronts us is the whole matter of competitive remuneration in respect of insured services. That matter is largely being played out right now in arbitration proceedings that have been going on between the province and the Manitoba Medical Association. We are hopeful that that outcome is going to be satisfactory to both parties, both to the province and to physicians. Obviously, it remains to be seen. The process is underway. It is lengthy. It is difficult. These processes always are. If there was some simple way of making everybody happy and solving all the problems, I am sure that someone else would have found it, and we would be applying simply that principle. It is not quite that simple, unfortunately. But certainly one very important aspect is that of competitiveness, and that is playing itself out right now.

I should also say that the Medical Association and the government have been able to reach agreement on a number of key areas of compensation in the last few months. This province had for many, many years suffered from an increasing shortage of anesthesiologists in Manitoba, a problem which was, I think fair to say, being felt throughout Canada, not only Manitoba but throughout Canada because of the large demand for these particular specialists. Ultimately, the province and the association were able to work out a new compensation arrangement in respect of these individuals, and I am pleased to see that already we are seeing some improvements in the retention of these individuals, particularly the new graduates coming out of the Manitoba medical school. So there is one example, and there have been other successes, in my view, in relation to that. Emergency physicians are another group that comes to mind. So we believe that it is important to keep working on these things. It is not easy. It is a question, I suppose, ultimately of balancing affordability from the perspective

of a government and sustainability at the same time. We are working towards trying to achieve that.

Mr. Chomiak: Mr. Chairperson, I have been advised that the benefit of incorporation could amount to a financial advantage of something in the area of $25,000 for a physician. I wonder if you might comment. Is that in the ballpark? Do you have any idea in terms of the financial implication of the process of incorporation?

Mr. Laplume: All I can tell this committee, Mr. Chairman, is that in consultations that we have had with our counterpart organizations in British Columbia, Alberta and so on, what they found is that–firstly, let me say that the vast majority of physicians will not incorporate their practices; the vast majority will not. We anticipate that the pick-up rate–if you can call it that–might be something approaching 20 percent within, say, the first five years, and we would not expect it to go over and above that. There are many different reasons why that is the case, but one of the primary reasons is that certainly there is a certain income threshold that has to be attained before incorporating even becomes a valid, cost-efficient sort of maneuver from the point of view of business and tax planning. So we are not anticipating that it is going to be picked up by anything approaching the majority of practitioners.

Having said that, I really could not even begin to speculate on what the tax savings might be. It might flow from very, very little in some circumstances to much more substantial, but I would think that the notion of $25,000 generally would be wildly optimistic–as much as I would like to see it–but I think that is wildly optimistic.

Mr. Chomiak: Mr. Chairperson, I thank you for those comments. You indicated that you had thought the pickup rate in the first five years would be something like 20 percent. Do you have any sense of who the typical, the atypical physician would be, what kind of practice or what kind of location or situation would warrant incorporation?

Mr. Laplume: The best sense I think I can give the committee, Mr. Chairman, is that the predominant interest that has been expressed to us internally has come principally from rural physicians and physicians in northern Manitoba. I think the reason primarily for that is that you might appreciate that many of our communities are relatively underserviced in the sense that you have one, two or three physicians operating in communities that really could reasonably sustain a far larger number. The result is that very often these practitioners work extremely long hours–60- and 70-hour weeks are certainly not uncommon–and that is in relation to direct care with patients. I am not including here on-call work, evenings and weekends and so on. What is happening, of course, is that the fewer physicians that there are, the harder those few who are working and their incomes tend to be much higher, which means their tax burden is much, much higher. So our sense is that the main interest is going to come from areas such as that.

I also know that because we have been in contact with organizations such as the Brandon Chamber of Commerce and others who have actually supported us and encouraged us to pursue that as a means of helping to retain physicians in rural Manitoba. So my sense is that is where we are going to see probably, at least in the early stages, a fair degree of the interest.

Mr. Chomiak: Mr. Laplume, was the MMA aware of the provisions in the bill dealing with physician assistants?

Mr. Laplume: Yes, the MMA was aware. The MMA has had discussions and consultations with the College of Physicians and Surgeons over this particular matter over a number of years, and so we were aware. The MMA has not established a policy per se. We are aware of what the college has in mind and the reasons for that, but the association has not taken a particular position, mainly because, as a general rule, the Manitoba Medical Association understands and respects that there is quite a clear dividing line between the responsibilities of the college in respect of licensing standards and discipline. On the other side of the dividing line are the responsibilities of the Manitoba Medical Association representing the professional interests of physicians. So we are aware of it,

but, as I say, we have not taken any particular position.

* (2250)

Mr. Kevin Lamoureux (Inkster): Mr. Chairperson, I did have maybe a couple of questions. Unfortunately, I did not necessarily expect this bill to be passing through second reading and before us this evening in committee, so I really have not had the opportunity to talk to my Leader who happens to be a practising physician.

An Honourable Member: Probably better if you do not talk to him.

Mr. Lamoureux: Fortunately, that, hopefully, will not be on the record.

Mr. Chairperson: Order, please. Mr. Lamoureux has the floor.

Mr. Lamoureux: Yes, thank you, Mr. Chairperson. The primary purpose of the legislation is, then, to assist in making practices more competitive. Is the driving force, then, for the legislation that we see other jurisdictions that are doing this and now Manitoba is catching up to that, or is Manitoba more so leading on this particular issue?

Mr. Laplume: Mr. Chairman, I guess it depends on your perspective. To the extent that six jurisdictions already have such legislation, I suppose we are catching up; to the extent that Ontario does not yet have it, I suppose we are ahead of them.

Mr. Lamoureux: Does the MMA have any analysis in terms of the impact that it has had in other jurisdictions? You have made representation in the question from Mr. Chomiak that it seems to have more of a favourable impact on rural communities. Is it a safe assumption then that the same will happen here in the province of Manitoba by this particular legislation?

Mr. Laplume: I cannot say that I am aware as to how the impact has spread out necessarily in the other jurisdictions. I was referring more to the expressions of interest that we have had internally from physicians in Manitoba. My sense, based on the comments that we have received from practitioners across Manitoba, is that, in particular, there is very strong interest out there outside the city of Winnipeg.

I have no doubt that there will be others in the city of Winnipeg who will be interested as well, but again, on the basis of what has happened in other jurisdictions, recognizing that it is costly, of course, to incorporate, it probably will be a minimum of $5,000 at least for the average practitioner to be able to set up a corporation in the first place. There is going to have to be a cost-benefit analysis made right at the start to see whether it is going to be worthwhile in individual circumstances.

Mr. Lamoureux: You know, I do not know if it is a valid argument and I look for you to give me some advice on it, because it is suffice to say that the costs of this are through taxation savings, primarily. Is there any idea in terms of what sort of a cost, something of this nature, that will cost the taxpayers ultimately?

Mr. Laplume: The association has not done any studies or analysis in relation to that. We have really looked at it merely from the basis of the principles involved. The vast majority of doctors in Manitoba are working on a fee-for-service basis. They are private practitioners. They run a private office. They pay overhead in respect of that office; they hire staff; they have to pay for supplies, no different than really, any other professional or any other person in business, and other people in business are able to incorporate their practices really for two reasons. One, of course, as you are probably aware, is the whole issue of limited liability, which this bill does not deal with.

We have assured the government right from the outset, and this has been the case in other jurisdictions as well, that the purpose of seeking this is not to somehow limit a doctor's exposure with regard to legal obligations in any way. The purpose of it is to simply try to put them in a similar position to other small-business persons who can have access to, in some circumstances, a somewhat lower rate of tax in regard to their business income.

Mr. Chairperson: Are there any further questions? If not, thank you very much for your

presentation. We will move on to our next presenter, Dr. Ken Brown, please. Dr. Brown. Do you have copies for handout?

Dr. Ken Brown (College of Physicians and Surgeons): No, it will be a verbal presentation.

Mr. Chairperson: Please proceed, Dr. Brown.

Mr. Brown: Thank you. Like my colleague whose birthday is today and who left his birthday party to come here–

Floor Comment: Many happy returns.

Mr. Brown: Thank you, for him. I do not very often find myself, in fact, we never find ourselves in opposition to the government, certainly not publicly. We regard ourselves as administrators of The Medical Act, and this is in support of the minister in the attempt to regulate the practice of medicine.

With respect to the section that Mr. Laplume talked about, we are basically standing by and allowing this to proceed with the sponsorship of the Manitoba Medical Association. It is not directly related to standards of practice. Our role with respect to that section will be to administer it when it is passed. As a result we will be involved in drafting the regulations which will make it operable.

I am here, however, to talk to the other points, that you may have the other points. I think Mr. Chomiak has already raised some questions to do with the clinical assistant. Maybe I will just give you some background information about the genesis of the clinical assistant. We have over the years developed a very good, functional working relationship with the MARN. Now, this began roughly about the time that I joined the College of Physicians and Surgeons with a document called The Delegation of Function. There is indeed a national document which was created as a result of the joint effort between the Canadian Medical Association and the Canadian Nurses Association, which also deals with the subject of delegation of function.

Without drawing this out too much, it is a series of conditions or criteria that you meet in order to ensure that medical activities can safely be performed by some other individual. The usual person who is involved in delegation of function has been the nurse, although not exclusively. We have a very good example here in the city with the ambulance system, and indeed the province the Manitoba. We are probably a leader provincially in the development of delegation of function for ambulance attendants and the development of independent function ultimately for these personnel. So the principles are not terribly different.

Doctors and nurses have a very interesting history. They are both very old professions. In some respects we overlap and in some respects we actually develop quite differently. The one thing we do share is a common body of knowledge, a common respect for science, and we have come to the realization that we can provide care in similar fashions. In other words, everything a doctor does is not necessarily exclusive to that physician. There are many things a physician does which come from a shared body of knowledge with other professions. We had the physiotherapists tonight. Physiotherapists perform many activities which are performed by physicians, and the physicians are very comfortable–I would agree with the speaker, by the way, who said he looks forward to the day when a physiotherapist would work in the emergency department and triage patients. I think that is a very reasonable expectation that we should have.

So doctors and nurses have had for many years a fluid working relationship in the very important area of primary care. It is out of this that has grown in the United States a very interesting practice. I will tell you why it has happened. In the United States they have 10 percent of their medical personnel in primary care. That contrasts to 50 percent in Canada. We are very fortunate in Canada, because our whole approach to medical education has been to emphasize the importance of the role of the family practitioner. That is why family practitioners in Canada are being, I am not sure what the polite verb is, enticed to move to the United States. That is because they are recognized as a very viable product. We put a lot of money into the preparation of our family physicians. But the basic difference is 50 percent

family doctors here, 10 percent in the United States, and that includes pediatricians.

So all the people in primary care in the United States have a tremendous hunger for primary care practitioners. They have been obliged to develop what are called the intermediate care providers. There are two main groups that have provided this service, the nurse practitioners, and you could argue whether that is a good term, advanced practice nurse, really I do not think it matters, and the physician assistant. The basic difference between these two is not really to be found so much in the knowledge base, not even necessarily in the internship, because they both have similar educational programs, they have similar internships, but actually in the orientation they have. It would be similar to saying two MBAs from different universities, one would be a humanist approach and one would be a chartered accountant approach. Why did I use that example? Not to suggest that chartered accountants are not humanists. I think I am in trouble, right? I am in trouble. Okay, so you would have these two providers.

* (2300)

Now, what is the difference in the orientation? Well, there is one big difference. The one is a physician extender, and that is somebody who is educated to realize that they are going to find their role in fulfilling the management program which is established by the physicians. So they are basically assisting the physician in the work. This is a physician-extender model. Their orientation academically is acute care medicine. It is interventionist in its primary philosophy, and the internship is largely served in acute care settings.

The other approach, which is the nurse practitioner approach, and this is a crass oversimplification, tends to come more from a humanist, a wellness orientation, a sound grounding in public health wellness, holistic approaches to health care, and, again, the internship and the clinical experience tends to reflect this kind of orientation.

Ms. Neilson referred earlier to the visit to North Dakota. What we found was that you would see 26, I think it was, nurse practitioners and something like 64 physician assistants working for the same corporation. The nurse practitioners tended to work in geriatrics, personal care facilities, well baby clinics, provide reproductive counselling and this type of thing, whereas physician assistants tend to gravitate toward emergency care, operating rooms and that type of thing. The two actually were relatively interchangeable, and many nurse practitioners were actually working in the role of physician assistants.

Now, I have no idea where we are going to wind up in Manitoba, but we have a good working relationship with MARN. Basically what you will find the main difference will be is if we have an intermediate care practitioner in a northern community and that northern community requires backup from a doctor, and a doctor is supervising, in all likelihood it will be a physician assistant. If the northern community is more isolated, a doctor is not available, the problems are primarily public health, it could be that they will say, no, I think we would prefer or could utilize the services of a nurse practitioner. You may see both and both could be working there. So I do not think it is a matter of saying either/or. I do not see it as a competitive system.

The other purpose behind the clinical assistant legislation is to allow an opportunity to provide staff for special care units. As you know, the emergency departments and intensive care units and so on have had a critical shortage of medical manpower. You can meet that need by describing very clearly what the skills are you need and what the body of knowledge is you need for the providers. If you can circumscribe it well enough and describe it well enough, then you can employ people after testing them to make sure they have the knowledge and the competency to work in this confined area.

So the first one they describe is working under the supervision of a doctor in a primary care setting, generally doing what the doctor says they can do but they cannot do anything the doctor cannot do. The second position I am talking about, the job description, is very clear. Again, there is the supervising physician. These people, however, may not have the broad competencies, and in this area we are looking at the possible employment of people who have a

technological background, people from the previous group, with the emergency ambulance attendants. International medical graduates would be potential recruiting groups. So we have these two entirely different uses for the clinical assistants.

Mr. Chairperson: Thank you for your presentation. Open for questions.

Mr. Chomiak: I appreciate the explanation. It helps to clarify the inclusion in this legislation of that particular category.

I am concerned that we are seeing the introduction of a new category of professional in this legislation without necessarily as clear an understanding of where we are going as perhaps I would like. I must admit, I was taken aback by the legislation. I was surprised at the legislation, and I indicated in my comments on second reading that, again, generally legislation of this kind is something that we generally do not have a problem with and generally passes as the three professional acts are passing unanimously, and this act will pass as well.

The inclusion of, to my mind, a significant change in the approach to health care in this act is something that I think perhaps would better be–and I appreciate that there has been some collaborative discussion but would bear prior discussion prior to the actual act coming forward. Now, again, I know you are not necessarily responsible for this and I have mentioned these in my comments, that I have some problems, to the minister personally. It makes it difficult to provide constructive and meaningful input when at the end of a legislative session in a bill that is dealing with largely matters of incorporation and other related matters we have the introduction to my mind of something as significant as an inclusion of an entire category.

This criticism, if that is what it is, is more directed at the minister. But this to my mind and to our mind is a fairly significant change. Perhaps I will stop. You may or may not want to comment, because I do have a series of specific questions.

Mr. Brown: I can fully appreciate your sensitivities, and I think if I were in your position and I were suddenly made aware of this clause, my reaction may have been the same. You know, what does this mean; what is it opening up; what portends?

In actual fact, it is not a new concept. It goes back actually now two years. We have published in our newsletter our intention to proceed at the first opportunity with the physician assistant. We have consulted fairly widely with nursing, which is our main professional group. I say that, in a sense, it is not–I think you could tell probably from Ms. Neilson's responses–as revolutionary from our perspective as it may appear.

Until I heard you speak, I had not fully appreciated the novelty, or it may appear to be novel. But, you see, we have been working through this process of shared function. We are very aware of the changes in legislation in Ontario. We are very aware of the fact that there are spheres of function. We are aware of the fact and have been for many years that doctors do not have exclusive jurisdiction over any particular area of activity, and we are very accustomed to moving in the direction of sharing roles. So it is a natural outcome of this process for us, rather than anything tremendously revolutionary, to give credibility to something which has been happening. That is what I have tried to explain at the beginning with the delegation of function.

* (2310)

The reality is that we have a diminishing number of doctors. We have a diminishing number of primary care practitioners. Although we have been very fortunate in having 50 percent of our population dedicated to primary care, they are shrinking. We are losing doctors for various reasons, and I do not think it is relevant at this point to say why it is called supplier control. It is a national and international phenomenon. If we are going to look at the process, we can either throw our hands up in horror and say, oh, my God, we cannot handle it, or if you are a regulatory body, say how do you rationalize this? How do you help doctors extend the care that they can give? How do you increase the span of control? How do you maintain emergency departments open in small communities which are currently being closed?

We know how it is done. We are not an island. Canada is living very close to our neighbours to the south, and not everything they do is stupid. I do not mean to be as frivolous as I think I sounded, but there are things to be learned, and there are things to be learned not to do, in the United States; I think more things to be learned not to do than to do. I think they do have a good model to show us. I think there is something very valuable in the model that has been developed and worked on.

We have consulted with the armed services, and I wish he was still here. Dr. Jenkins [phonetic], with the armed services, was responsible for the training of the Canadian equivalent to the physician assistant. There is a training program within the armed services, and it was that model that we discussed with our membership at various meetings with the MMA and shared with nursing and led to our subsequent meetings to the south.

So I am trying to give you background of what to us was not as revolutionary. Now, the fact it got into the act I think is more serendipity than anything. There was no deliberate intent for it to slide in. It is probably a small section. I get that impression, and all this business about incorporation is immense. It takes up most of the stuff. The clinical assistant process is enabling, so it allows us to move forward from what we have been doing now for a period of many years, specifically the last two.

As Ms. Neilson said, we have a meeting set up tomorrow to discuss the gradual development of regulations. In view of the increased sensitivity you have given me, Mr. Chomiak, I will certainly consult with you to ensure that that group involves people whom you think may have been–if excluded, it was thoroughly unintended. But we are trying to be as broad in our consultation in the development of regulation as we can.

Mr. Chomiak: I thank you for those comments. Essentially the intention is to be proactive in recognition of the fact that we will no longer be able to provide the extent of primary care by medical doctors that we presently do today. Is that a fair comment?

Mr. Brown: I think that is a relatively good summary. It puts a little bit of a different spin on it but, yes.

Mr. Chomiak: I tend sometimes to put different spins on. One of the concerns that has been addressed to me on this issue is that the establishment of this registry will make it very difficult for someone to move from this registry to another registry. Can you comment on that, or do you need more elaboration?

Mr. Brown: I think I know what you are referring to there. It will not be more difficult or less difficult. No movement is envisioned in Part 2 of the registry. Part 2 of the register deals with those who are intended to be employed as nonphysicians but performing medical functions.

Now could I give you an example of a position which may be confusing? I thought I would bring it out and maybe clear up the confusion. One of the areas we have been looking at, which has to do with the second use of the clinical assistant, is a bone marrow transplant unit. This is a unit that has very particular and specific medical requirements. They require 24-hour-a-day attendants for their patients, and they have a very specific body of knowledge, a particularly demanding kind of process, so they do need medical care for their patients. It is also circumscribed.

Some international medical graduates have been very successfully employed in that unit. I wish I had known, getting into this; I would have brought the figures. The figures are dramatic, something like 10 or 12, and I will get the correct ones for you, but roughly 10 or 12 physicians have gone through that program, which is not primarily educational, but there is an element, obviously, of education in it. During the period they had been there, they had been able to satisfy the licensing requirements and are indeed now licensed or in residency training programs.

That was not the intent of the bone marrow transplant program, and it is not our intention that, by creating the capability of employing people to work in that area, they necessarily or should expect to become licensed to practise. We would prefer that they see that their role is to

work with the bone marrow transplant unit or any other unit which is so designated.

The Winnipeg Hospital Authority has conducted an extensive study of all of the possible locations in which such people could be employed, and I think it is possible to consider that some may actually be transportable from place to place. There may be some units with sufficient similarity that there could be some movement, but it is not contemplated that those working in those units approved as registered clinical assistants would necessarily or should expect to go on the medical register. On the other hand, if they were to gain the knowledge, if they were to gain the capacity, the additional ambience that gives them confidence and they happen to be successful, so be it, and that would be good. Am I explaining that?

Mr. Chomiak: Yes, thank you. I think that is fairly clear. Let me pose a slightly different question then. This is not seen as a vehicle for a person generally who, say, has a degree from a foreign country in medicine to be used as an access to become a medical doctor. Is that correct?

Mr. Brown: That is correct, sir.

Mr. Chomiak: It is not the intention, but it would not be out of the realm of possibility.

Mr. Brown: That, again, is correct.

Mr. Chomiak: You indicated that the Winnipeg Hospital Authority had identified some areas of potential. I assume that the other regional health authorities have also identified particular areas where the Part II individuals might apply. What are we talking about in terms of numbers? Are we talking about dozens or hundreds? What are we talking about?

Mr. Brown: I could not honestly give you an answer. I know from the brief study I read that we are talking in terms of not large numbers; we are talking roughly 10 or so physicians that have been identified in the Winnipeg Hospital Authority. So we are not talking about a major program. We are creating a legal capability of providing a necessary service. Whether or not that would exist in other regions, that is a good question. We have not consulted with the others. The impetus for this particular area—I will give you the background of it—was the bone marrow transplant crisis that we are running into, so there are units that are particularly up against it from the point of view of being able to retain medical manpower, and most of those happen to be in the city. But we would, of course, consult further, and if it could be more broadly implemented, certainly it would be.

Mr. Chomiak: Am I correct in assuming, then, there is not a specific education program that is being considered to train specifically physician assistants, but rather it is the intention to approve programs in various areas where there is need to employ physician assistants? Do you see what I am getting at?

Mr. Brown: I think so. The approach will be somewhat different for the two positions. The second one that I am talking about will consist of a job description, and, in addition to the job description, it will have a site description, so in this case let us look again at the bone marrow transplant unit. We would want to know the specific kind of patient needs that are going to be met, who is supervising the unit, what kinds of patient care levels are there with respect to acuity, and then, in the job description, what kind of knowledge, what kinds of skills are necessary to meet them.

We do have a very good assessment program which has been developed with the Faculty of Medicine through continuing medical education which, again, is a tremendous star for Manitoba. It is really quite exemplary from a national perspective. They have developed testing capabilities which allow us tremendous abilities to assess, and we hope that they will be able to assess the knowledge base and the skills to confirm that an individual would be appropriately employed in these units. So it would be matching the person with predetermined knowledge and skills and saying: yes, you may apply for that position; you are eligible to be accepted.

* (2320)

When it comes to the other position that we are talking about, developing, and that is going

to be more difficult to discuss with other professional groups, we would be looking at certification programs. There has been a program developed for nurse practitioners in Manitoba. That would be a potential source of people. There is a certification process in Atlantic Canada. There is the physician assistant program I talked about that the federal government has developed. There is an examination process already in place in the United States. So all of these are possibilities.

We could require, for example, certification of the American centre in order to test the knowledge base. But what we will be doing here is looking more at certification, of having met general requirements with respect to knowledge and skills to work generally with the supervision of a physician with no limits. These people will do virtually anything the supervising physician authorizes them to do. The only requirement, there will be a job description which the supervising physician will be obliged to develop. We have prototypes that we are looking at that we think are particularly useful from Oregon and North Dakota. These we will be discussing with other groups, the group I was telling you that would be pleased to involve whoever you would like to involve as we develop the regulations.

Mr. Chomiak: When you refer to the other positions, were you referring to the Part 1 provisions, or were you referring to another component of the Part 2 provisions?

Mr. Brown: I am sorry, I did not get that.

Mr. Chomiak: When you elaborated on the series of education programs, for example, the military program and the general certification programs where needs will be met, is that in reference to Part 2 certification or Part 1 certification?

Mr. Brown: I was trying to comment there on the first of the two clinical assistant groups described. I think it is called Part 2. Part 2 consists of two different types of–

Mr. Chomiak: Okay, right.

Mr. Brown: Okay.

Mr. Chomiak: Thank you then. Okay, I understand then that the second reference was probably to Section (b) of Part 2.

What is Part 1, Section 11(1) division referring to then?

Mr. Brown: I do apologize if I have misused Part 1 and so on. I hope I have been clear.

Part 1 is the remnants, if you will, of the previous educational register. Part 1 consists of the students. We, in Manitoba, register students on the day they enter medical school. So those who are going through a continuum go through a process of graduated increasing responsibility. When the medical student reaches the point where they are coming to their bridge or where they are beginning to touch patients, we have an additional process we go through where they begin their registration. After that, they begin to be more in touch with patients. Ultimately, they become eligible for medical register as they conclude their examination. But the Part 1 are potential physicians; the Part 2 will be registered clinical assistants as their end objective.

Mr. Chomiak: Thank you for that clarification.

Regardless of whether it is Part 1 or Part 2, although I suspect we are mostly talking about Part 2, do I understand it correctly that the clinical assistant will be under the direct or indirect supervision of a physician? Can you elaborate on that?

Mr. Brown: I think it is probably easier if you forget about direct or indirect and you just say supervision, because this is again the essential difference between the intermediate care provider who comes from the nursing orientation and the registered clinical assistant from this orientation. There will always be an identified supervising physician. The important point here is that the individual we are talking about–I think you made the point earlier, a new provider, we are not talking about a new provider. We are talking about somebody who will literally implement the management program which is compatible with that which the attending physician implements. So our attitude is that

there must be an attending physician responsible for every patient at all times, and only one.

That attending physician can expand their span of control, if they have somebody in whom they have confidence, will, for example, give foot care; will, for example, do examinations; you name it. It is a very wide range of activities. The doctor knows, by working with them and developing a job description, that they are working within their job description, they are working within their area of competency, and they are doing things which that physician will also do.

So we would not be entertaining here somebody who Dr. Jones talks to and they have a conversation about patient Mary Smith. They say: well, how was Mary today? You know, I think I would recommend that you give Mary antibiotic A. So the individual hangs up the phone and says: now that is an interesting thought. I will put that together with all my other thoughts and decide on my own to give antibiotic B. That would not occur in this concept. In this concept, there is complete congruity, that the assistant would do what the physician expects to be done.

There is nothing wrong with the other model. There is nothing wrong with somebody exercising complete independence; however, then you have to create an awful lot of tests of scope competencies and so on. It is a different way of approaching the provision of primary care.

So what we are after here is somebody who will literally work with that physician, who wants to work with that physician, who finds it rewarding to work with that physician, and will literally be an extender of that physician's capability. The potential range of opportunities go from primary care to specialty care. In the United States where it first started, almost all of the first physician assistants worked in primary care settings on First Nations reservations. Now over 50 percent are working in specialty areas. So it shifts.

Mr. Chomiak: Thank you. That is a very interesting statistic, because it does lead to the two schools of thought in terms of this particular function. Let us use the North as an example. There is the one school of thought that says this is terrific for the North because the North will get access to all kinds of primary health care directly. The other school of thought says this is lousy for the North because all the North is going to get is physicians' assistants and is not going to get medical practitioners. It is interesting that you pointed out that it went from 50 percent primarily on reservations to actually specialty in terms of its evolution. How do you see it working in underserviced areas of Manitoba?

Mr. Brown: When you think of a remote area, try to imagine the situation from a primary care point of view. Most of our remote areas, and I am excluding now things where we have a bunch of people from Winnipeg who are living out in a little camp up there. I am talking about communities that are forced to survive through their own means.

Most of the care requirements they have have to do with nutrition, sanitation, how do you maintain the economy of the area, how do you keep people away from sniffing glue, how do you keep a good quality of health in the community? And actually most of the morbidity and mortality we are seeing stem from these kinds of faults. If what you are looking at is a community which could be pictured along those lines, probably what you are talking about then is somebody who is going to spend a lot of their time in these primary preventive areas, with very little time spent in acute care.

So you say, all right, what am I going to do then if somebody becomes acutely ill? Well, think about it a bit. Acute illness in this type of community is not going to happen too often, and you do not remain competent to handle acute illness by seeing something once a month or once a year. So how do you handle that?

Well, there are a few ways you can go about it. The one way you can go about it, you can start off saying, well, let us address the major problem and get a nurse practitioner in here who is competent in all these areas but busy doing them and will maintain her skills. She may or may not be able to maintain her skills in acute care, but we will live with that. We will live

with that because we know we can evacuate people out.

* (2330)

On the other hand, you might have a somewhat different community, and you say, no, this is a little bit more stable community. We have most of the public health problems in control. They are still there. We still have a problem with alcoholism. We still have a problem with unwanted pregnancies that we need to deal with, but really what we have a problem with is we have several communities coming in here, we have a lot of hunting accidents, we have a lot of knife injuries, we have had a lot of elderly people beginning to move in there. They are sick. We need a physician extender. We will live with the fact the physician extender may not be quite as current or have as much background in the public health area. So we have the physician extender there. The physician extender works out of, say, the Kildonan Clinic. I am using that fictitiously, I hope you realize. So the doctors in Kildonan Clinic may visit that physician extender once a week or the physician extender goes into Kildonan Clinic from time to time and basically functions as part of Kildonan Clinic or a physician in the Kildonan Clinic. So it is an extender. And the best I can do is hope those two different ways of approaching it, I do not see these as conflicting. I see these as entirely different ways of approaching the provision of care. They are compatible.

Mr. Chomiak: When you say they are compatible, you are referring to the nurse practitioner and the physician extender. Do I understand that correctly?

Mr. Brown: That is correct.

Mr. Chomiak: I appreciate this and I am sorry to go at such length, but this is significant and we do need to know this information dealing with this bill. The conclusion I am reaching is, we initially discussed the fact that it did not appear that we are going to be creating a new level of professional or paraprofessional under provisions of this act. The discussion, though, and the evolution of this discussion leads me to believe that in fact that is where we are planning to go, that we will be going towards a physician assistant, an extended physician in conjunction with a nurse practitioner or a holistic provider, if we can put it in that sense, but it seems to me that in fact we are going towards the creation of another level, that this is enabling legislation to in fact do that. Is that a fair assumption?

Mr. Brown: I think that is fair. Of course it is. Otherwise we would not be going for the legislation. The legislation is intended to create an opportunity for the introduction of an intermediate care practitioner. My understanding is, you have the same balancing kind of legislation available now within The Nurses Act. There will also be similar clauses in The Medical Act. We plan to work together to ensure that these kinds of orientation–but, yes, you are right. They are both novel and maybe I am being too quick to dismiss them as evolutionary. You are quite correct. They are not just evolutionary, they are also a milestone, because we are moving forward. This is in a sense a new area.

Mr. Chomiak: You certainly indicated, and there seems to be, a communication and good will between nurses and the medical profession, between the nursing profession and the medical profession with regard to the evolution of these positions, but there is an element who will express concern that, having now achieved in legislation the ability to actually have nurse practitioners, this legislation may stand in the face of that and may counter that. I wonder if you might comment on that.

Mr. Brown: I would be the first to recognize not only what you are saying but further that I hope I have not given you the impression that in any way I am speaking for the medical profession. I mean, I hope I have not given the impression that the proposal that we have is supported unanimously throughout the medical profession. There will be a lot of angst within the profession, from some more than others, and that is why we are going through as much collaboration as we can. That is why I value the comments you have made.

The regulations cannot be created by the college. The regulations do have to go to cabinet, and all I can tell you about that is I

know there is opposition. I know there is opposition here, here, everywhere. We think it is a sensible idea. We think it is a very useful direction to go for Manitoba. I guess that, if we were unable to show that it is logical and helpful to Manitobans, our regulation will not pass.

Mr. Chomiak: Several years ago general medical practitioners were permitted to practise as psychiatrists to provide psychiatric services in underserviced areas. Now, we did not need the legislation. I think we have to change regulations to do that. You can correct me if I am wrong. Is it also a vision that this provision will apply at all to physicians, or is that not in the cards? In other words, you could take this legislation and allow a physician to practise in some other capacity, some other specialty.

I guess conceivably it could happen by the way the legislation is worded.

Mr. Brown: You have a very good memory. I thought I was the only one who remembered that. You have to go back quite a ways. What you are talking about did indeed occur. It had absolutely nothing to do with The Medical Act. We could, within The Medical Act today–you know we have the specialists registered–maybe I will hark back to earlier the conversation on Bill 26. I was quite intrigued with the way the discussion went there.

The way The Medical Act works we do not control procedure by procedure. We say to you: you are now qualified in primary continuing care. We are the only province that has defined registration. I think we are the only jurisdiction in North America, much less the only province. So this is a very unusual thing we do. We say to you: you are now licensed in primary continuing care. We do not say that you can put an incision, you may open that person's forearm but only below the elbow and not above the shoulder, or whatever it is, because the body of knowledge and the skills that you are taught tell you what you may and may not do. Now, in the same way, any doctor who is licensed in primary continuing care, which is the most general registration we give, can practise psychiatry until we find that they practise incompetently in the area. Then we do an exclusion, and we say: you may no longer practise psychiatry. Since I have been registrar, we found it necessary to do that only three times.

So we have the authority within our regulations to say: indicatively, you may do this, this, this, or you exclusively may not do this, this, this. We actually define what you may or may not do. Generally speaking, the only field which is exclusive is radiology, which is a peculiarity we could go into. But the only field of medicine which could be practised only by a radiologist is radiology. All other fields can be practised by anybody. The test is whether or not they do it competently, and if they practise it without evidence of competence, the regulatory body deals with it.

We say to you that you should show competence by means of specialty qualification. So, for example, if you are going to say you are a cardiologist, go out and get the credentials required to tell the public you are a cardiologist. But without those qualifications may you practise cardiology? Sure, just do not tell the public you are a cardiologist.

* (2340)

So the latitude available of The Medical Act is immense. It covers everything from cleaning the washroom right through to doing heart transplants. There is nothing in the act which limits any particular person in any particular way. What we do is try to inform the public what the credentials of the people are, whether they are competent to do what they are doing. But we do not tell each person a list of what you may or may not do.

Mr. Chomiak: Two groups are going to approach me on this act, and I am sure they will approach the minister, and they may approach the college and ask what effect this portion, that is, the clinical assistant portion, will have on their future. The first are graduating or potentially graduating students from medicine who are very happy, and many are very happy to see an expanded graduating class, something I am going to pursue with the minister later on in the course of this discussion. The second group, of course, will be the Canadian foreign-trained physicians. I wonder if you might help me out as to how the college views both of these groups

vis-a-vis this legislation, specifically dealing with the clinical assistant registry.

Mr. Brown: When we had a discussion at council about this whole concept, and we have discussed it many times at council because it has been out in the press for so long, I think it is fair to say that most of the agitation and apprehension came from a generation just slightly below mine and up. The newer physicians, the younger physicians, many have worked with physician assistants or intermediary care practitioners of one type or another, and there is a level of comfort.

There is a lot of interdisciplinary education that now takes place within the Faculty of Medicine. There is greater exposure to working with different health professionals, and I think the basic thing is if you show it is logical and it makes sense and you are not just doing something to make a lawful point, people go along with it. I think most of the difficulty will be with the older physician.

The Canadian physician, you are talking about a Canadian citizen who was foreign trained? The main problem these doctors have, as you are probably very well aware, is in accessing those graduate education programs. It is very, very difficult. These changes will make no difference, will have no effect on them at all, none.

If I am assuming an implication which you may not have intended, but does this in some way solve some impending physician shortage to the point that we will have a glut? No, because it is all dependent upon the supervising physician. It will be like jobs available. You have a group working in Hamiota, three doctors, can they or can they not effectively employ one or two physician extenders? If they can, they will hire them. If they cannot, they will not. So you are not going to go beyond the need to serve the needs of the population. You cannot have a hundred physician assistants running around doing things unsupervised. They are probably more controllable in a sense than the medical population.

Mr. Chomiak: But it would be conceivable, to use the example that you used earlier, for a physician in a Kildonan medical practice to have a practice in all of northern Manitoba and employ half a dozen or eight physician extenders, that that would not be allowed? And supervising, is it a one-on-one? How can we say definitively that that will not happen?

Mr. Brown: I am not aware of any span of control exceeding more than two. I am not aware of any jurisdiction that has ever contemplated more than two physician extenders being able to work under the supervision of one doctor. That is simply a matter of the reality of span of control. It is simple management of principles. You have to, after all, submit the job description. You have to comply with the regulations which require a certain minimum number of onsite supervisions, and you just logically cannot do that and also take care of your own patients. This is an extender. This is not somebody whom you are hiring in order to do your work for you like some sort of franchise operation. That would be inappropriate and not consistent with the intent of the physician extender. It would not be allowed.

How do you know it is not going to be allowed? Well, I guess the same way that you know that we would not allow me to take out your appendix, even if you were foolish enough to let me.

Mr. Chomiak: Just on a tangential question, will we be seeing in this year's graduating class a larger admission to this year's class of students at the Faculty of Medicine?

Mr. Brown: I cannot answer the question. I do not know. I have no idea what the discussions are between the university and its entry allowance.

Mr. Chomiak: Does the college have any problem with a larger class?

Mr. Brown: No, we have already stated our concern in our newsletter that the population of physicians who are exiting our medical schools is now roughly at the 1975 level. We are concerned that the Canadian production is, in our view, inadequate.

That is a general thought. I do not think it deals directly with the issues that we are looking at in this legislation. But it is there. Yes, it is a concern. We have a lot of concern about that.

Mr. Lamoureux: I have found the dialogue most interesting and quite educational, to be quite frank. It was over a year and a half ago I was having some discussions with the former Minister of Health and talking about what I believe many Manitobans recognize, and that is the abilities and talents that many of our nurses have and how that talent could, in fact, be better capitalized on in terms of providing additional health care services.

So when you talked about nurse practitioners, in fact last year whether it was through Question Period or through the Estimates, I pushed the government in terms of trying to see some progress in that area. It is a bit of surprise, as I had indicated to the earlier presenter, that I was not aware of the bill actually coming in through second reading today and then into committee.

Having said that, I think that there is a lot of reason to be somewhat optimistic in the sense that we are seeing some recognition. But the question that I would have is more so one of acknowledging that, if we are to proceed forward with the idea of expanding that role into the nurse practitioner or what many have envisioned what a nurse practitioner is–or there are other terminologies that one could use in replacement of nurse practitioner–it is absolutely critical that the other stakeholders be involved in that dialogue. It caused some concern for me personally. For example, there was at least one presenter that indicated that they were not necessarily aware of this. I would, I guess, ask, doctor, if you could comment on the importance of ensuring that, in the future–because I think this is just a steppingstone, we are actually going to see this expanded, if you would agree with me that it is absolutely critical that all stakeholders be brought into the circle so that the dialogue is quite positive and that we do not see undue resistance by not moving forward in a collective fashion.

Mr. Brown: I think I fully appreciate the points you are making. I can only reassure you that there has been no intent to exclude anybody. I think that, had you gone on with your questions, which you had not done, and it may be presumptuous of me to say this, but had you gone on and asked psychiatric nursing, LPNs, whether they were offended or had a concern about lack of consultation, I hope they would say they were not concerned. I think our credibility is good with these groups. They know that we will involve them. They are not being excluded. They may not have been involved to date, but they will be involved.

The main group that is concerned with the development at this point, a primary, and I stress the primary, continuing care aspect, is really the MARN. They are the biggest one. To put it very bluntly, if we can make it work together, the MARN and the college, to develop this intermediate care practitioner in a way that is effective for the population, it will be available to other groups as appropriate. I mean, this is our big hurdle; this is the big hurdle to work through this co-operatively and develop a program that can be effectively put in place to meet health needs of Manitobans, then fine. If you come through another route, as a technologist, as an ambulance attendant, great, because what we would be doing is reaching certification requirements. It does not matter whether you are a nurse or whether you are a medical student who decided not to be a student, there are many possible ways in which you could access the certification process down the road.

* (2350)

Mr. Chairperson: Thank you. Any further questions? If not, thank you very much, Dr. Brown, for your comments tonight. Thank you.

Are there any other persons wishing to make presentation tonight? Seeing none, then we shall proceed. Did the committee wish to consider the bills in numerical order? [agreed] Okay, then we will proceed that way. Is there agreement from the committee that the clauses in the bills will be called in blocks of clauses conforming to the pages with the understanding that committee will stop at any clause where a member has asked questions, raised concerns or where there are amendments to be made. Thank you.

Bill 26–The Physiotherapists Act

Mr. Chairperson: Does the minister have an opening statement?

Hon. Eric Stefanson (Minister of Health): No, I do not, except just to put on notice that I have a very minor amendment in Clause 3(1)(a), an addition of three words. It is a very minor amendment. Thank you.

Mr. Chairperson: Okay, thank you. Does the official critic have–no comment. We thank you for that.

Is there agreement from the committee to consider the bill in blocks of clauses? [agreed] We shall proceed.

Clause 1–pass. I need to move back. The preamble and the title are postponed until all other clauses have been considered in their proper order and the table of contents.

Clause 1–pass; Clause 2(1) to 2(2)–pass. Clause 3(1), and there is, I believe, an amendment.

Mr. Stefanson: I move

THAT clause 3(1)(a) be amended by adding "as a physiotherapist" after "practice of physiotherapy".

[French version]

Il est proposé d'amender l'alinéa 3(1)a) par adjonction, après "physiothérie", de "à titre de physiothérapeute".

If you look at some of our other bills, the nursing legislation and so on, you will see that that reference is consistent, although I will have a similar amendment, I think, for the LPN bill.

Mr. Chairperson: Would the minister move that in English and French, with respect to?

Mr. Stefanson: Yes.

Mr. Chairperson: Is there anyone to speak to the amendment, any debate?

Amendment–pass. Clause 3(1) as amended–pass; Clause 3(2)–pass; Clauses 4(1), 4(2), 4(3), 4(4), 4(5), 4(6), 5(1) and 5(2)–pass; Clauses 6(1), 6(2), 6(3), 6(4), 6(5), 6(6), 6(7)–pass; Clauses 7(1), 7(2), 7(3)–pass; Clauses 8, 9(1)–pass; Clauses 9(2), 9(3), 9(4)–pass; Clauses 10, 11(1), 11(2), 11(3)–pass; Clauses 11(4), 11(5), 11(6), 11(7), 12(1) and 12(2)–pass; Clauses 13(1), 13(2), 14, 15(1)–pass; Clauses 15(2), 15(3)–pass; Clauses 16, 17(1), 17(2) and 18(1)–pass; Clauses 18(2), 19, 20(1) and 20(2)–pass; Clauses 20(3), 20(4), 20(5), 20(6)–pass; Clause 21(1)–pass; Clauses 21(2), 21(3), 21(4), 22(1), 22(2), 23(1), 23(2)–pass; Clauses 23(3), 24(1), 24(2), 25–pass; Clauses 26(1), 26(2), 26(3)–pass; Clauses 26(4), 26(5), 27(1), 27(2), 28–pass; Clauses 29, 30, 31(1), 31(2), 32(1), 32(2)–pass; Clauses 32(3), 32(4), 33(1), 33(2), 33(3), 33(4), 34(1)–pass; Clauses 34(2), 34(3), 35(1), 35(2), 35(3), 35(4), 36, 37(1)–pass; Clauses 37(2), 37(3), 37(4), 38(1), 38(2)–pass; Clauses 39(1), 39(2), 39(3), 39(4), 39(5)–pass; Clauses 40, 41–pass; Clause 42(1)–pass; Clauses 42(2), 42(3), 42(4), 42(5)–pass; Clauses 43(1), 43(2), 43(3)–pass; Clauses 43(4), 44(1), 44(2), 44(3), 44(4), 45, 46(1)–pass; Clauses 46(2), 46(3), 47, 48, 49–pass; Clauses 50(1), 50(2)–pass.

Mr. Dave Chomiak (Kildonan): We did discuss the issue of liability insurance in depth, and it is fairly clear to me that this section is not mandatory, but it is fairly clear to me that the college and the government, through order-in-council, are effectively going to make it mandatory. Am I correct in that assumption?

Mr. Stefanson: Mr. Chairman, yes, the member is correct.

Mr. Chomiak: If that is the case–I mean, I assume it is because other legislation does not make it mandatory–but why would the legislation not make it mandatory rather than in the manner and the fashion that it is designated here if in fact that is going to be the effect?

Mr. Stefanson: I think we did touch on most of that during the discussion that, as the member already indicated, this is consistent with other legislation for nurses and midwifery and The Medical Act and so on. It will allow the opportunity to look at the levels of coverage,

whether it is across the board, to all physiotherapists, whether there are differences between private practice, the whole issue even of carriers and common carriers and so on. So it does allow that to be dealt with through regulations as opposed to attempting to spell all of that out in legislation.

* (2400)

Mr. Chomiak: Just for clarification, I presume this act will not come into effect until the regulations have been drafted, until the orders-in-council have been put through, so it will all happen simultaneously? Am I correct in that assumption?

Mr. Stefanson: Yes, the member is correct.

Mr. Chairperson: Clauses 50(1), 50(2)–pass; Clause 51(1)–pass; Clause 51(2) and Clause 52–pass; Clauses 53(1), 53(2), 54(1), 54(2)–pass; Clauses 54(3),54(4), 55(1) and 55(2)–pass; Clauses 56, 57 and 58(1)–pass; Clauses 58(2), 58(3), (58(4), 58(5), 58(6), 58(7), and 59–pass; Clauses 60, 61 and 62–pass. Clauses 63, 64(1), 64(2) and 65(1).

Mr. Chomiak: Just a clarification on Clause 65(1), the provision says: "Every person who employs a person as a physiotherapist shall ensure that the physiotherapist is registered under this Act . . ." Does that imply that the physiotherapist being registered under the act will also have liability insurance or does that not imply that?

Mr. Stefanson: This section has nothing to do with liability insurance. It just ensures that when employers are employing somebody that they think is a physiotherapist that that is in fact the case.

Mr. Chomiak: I agree with the minister on that. I guess the question is: does being registered under the act equate to having liability insurance or not? Is that a prerequisite to being registered? I do not think so, but I just want to clarify that.

Mr. Stefanson: It is getting late. Just to be sure the member, the way I understood the question, was still relating it to this Section 65(1) and I think asked the question whether to be registered the individuals would have to be covered by liability insurance. The answer to that would be no, but it still goes back to the issue of what the regulation will ultimately say in terms of the liability coverage of physiotherapists working in different environments, if they are working in private practice, if they are working in the employment of some other organization.

So I guess I go back to what I we have discussed at length. The liability issue will be covered under that regulation. This is simply the confirmation that a person is registered as a physiotherapist when somebody is hiring them.

Mr. Chomiak: I agree with the minister. It is really a question of responsibility and whose responsibility the liability flows from. One would assume it is certainly the employer is indicated, of the physiotherapist. I think he indicated tonight that none of them would hire unless the person had the appropriate coverage, but because we covered it so much, I mean, there is an interesting issue about whether or not one can be part of a registry without having liability insurance, but again, I am assuming the regulations will take care of those issues.

Mr. Chairperson: Clauses 63, 64(1), 64(2) and 65(1)–pass; Clauses 65(2), 66(1), and 66(2)–pass; Clauses 67(1), 67(2), 67(3), 67(4), 67(5), and 67(6)–pass; Clauses 68, 69, and 70–pass; table of contents–pass; preamble–pass; title–pass. Bill as amended be reported.

Bill 36–The Registered Nurses Act

Mr. Chairperson: I want to move on to Bill 36. Does the minister have an opening statement?

Hon. Eric Stefanson (Minister of Health): No, I do not, Mr. Chairman.

Mr. Chairperson: Does the member for the official opposition have an opening statement? Okay.

During the consideration of the bill, the table of contents, preamble and the title are postponed until all other clauses have been considered in their proper order. We will move right on to the next part.

Clause 1–pass; Clauses 2(1), 2(2) and 3(1)–pass; Clauses 3(2), 3(3)–pass; Clauses 4(1), 4(2), 4(3), 4(4), 4(5) and 4(6)–pass; Clauses 4(7), 5(1), 5(2), 6(1), 6(2), 6(3) and 6(4)–pass; Clauses 6(5), 6(6), 6(7), 6(8)–pass; Clauses 7, 8(1), 8(2)–pass; Clause 9(1)–pass; Clauses 9(2), 9(3), 9(4) and 10–pass; Clauses 11(1), 11(2), 11(3), 11(4), 11(5), 11(6) and 11(7)–pass; Clauses 11(8), 12(1), 12(2), 12(3), 12(4) and 13(1)–pass; Clauses 13(2), 14(1), 14(2), and 14(3)–pass; Clause 15–pass; Clauses 16, 17(1), 17(2), 18(1)–pass; Clauses 18(2), 19, 20, 21(1)–

Mr. Stefanson: Mr. Chairman, there are no amendments. There does not appear to be any opposition. Can you do it on a more all-encompassing basis in terms of passing the bill?

Mr. Chairperson: Is there agreement to pass the bill in totality, that would be Clauses 18(2) to 70–pass; table of contents–pass; preamble–pass; title–pass. Bill be reported.

Bill 37–The Licensed Practical Nurses Act

Mr. Chairperson: Bill 37. Does the minister have an opening statement?

Hon. Eric Stefanson (Minister of Health): Just briefly, Mr. Chairman. This bill, I have two very minor amendments in Sections 3 and 6 that I will introduce when we get to those sections. Other than that, we would like to see the bill pass.

Mr. Chairperson: Does the member for the official opposition have an opening statement?

* (2410)

Mr. Dave Chomiak (Kildonan): Subject to a review of the amendments, Mr. Chairperson, we do not have any problem with passing the bill in its totality.

Mr. Chairperson: Thank you. During consideration of the bill, the preamble, the table of contents, and the title are postponed until all other clauses have been considered in their proper order.

Clause 1–pass; Clause 2–pass. Clause 3(1).

Mr. Stefanson: Mr. Chairman, I move

THAT clause 3(1)(a) be amended by adding "as a licensed practical nurse" after "practice of practical nursing".

[French version]

Il est proposé d'amender l'alinéa 3(1)a) par adjonction, après "profession d'infirmière auxiliare", de "à titre d'infirmière auxiliare".

A similar amendment to one introduced earlier.

Mr. Chairperson: Amendment–pass; Clause 3(1)(a), as amended–pass; Clause 3(2)–pass; Clauses 4(1), 4(2), 4(3), 4(4), 4(5), 4(6), 4(7)–pass; Clause 4(8) and Clauses 5(1), 5(2), Clauses 6(1), 6(2), 6(3), 6(4)–pass; Clauses 6(5), 6(6)–pass. Clause 6(7), I believe there is an amendment.

Mr. Stefanson: Mr. Chairman, I move

THAT subsection 6(7) be amended by adding "and" after clause (b), by striking out clause (c) and by renumbering clause (d) as clause (c).

[French version]

Il est proposé que le paragraphe 6(7) soit amendé par suppression de l'alinéa c) et par substitution, á la désignation d'alinéa d), de la désignation c).

Mr. Chairperson: Amendment–pass. Clause 6(7).

Mr. Chomiak: With full approval, Mr. Chairperson.

Mr. Chairperson: Clause 6(7), as amended–pass; Clauses 7(1) through to 71–pass; preamble–pass; table of contents–pass; title–pass. Bill as amended be reported.

Bill 38–The Registered Psychiatric Nurses Act

Mr. Chairperson: Moving on to Bill 38. Does the minister have an opening statement?

Hon. Eric Stefanson (Minister of Health): No, I do not, and I do not have any amendments, Mr. Chairman.

Mr. Chairperson: Does the honourable opposition critic? There are none.

During the consideration of the bill, the preamble, table of contents and title are postponed until all other clauses have been considered in their proper order.

Clauses 1 to 71–pass; preamble–pass; title–pass; table of contents–pass. Bill be reported.

Bill 39–The Medical Amendment Act

Mr. Chairperson: Does the minister for Bill 39 have an opening statement?

Hon. Eric Stefanson (Minister of Health): Mr. Chairman, I believe members would prefer to stand this one over to potentially a committee meeting tomorrow.

Mr. Chairperson: Is it the will of the committee to stand Bill 39 to a future meeting? Is it the will of the committee? [agreed]

Thank you very much. Committee rise.

COMMITTEE ROSE AT: 12:13 a.m.

WRITTEN SUBMISSIONS PRESENTED BUT NOT READ

Mr. Premier, Ministers and other honourable members:

I am a licensed physiotherapist practising in a private physiotherapy clinic in rural Manitoba and am privileged to have this opportunity to address you, in writing, regarding Bill 26.

I personally believe that Bill 26, in its present state, is a very positive step for the general public, government and physiotherapy professionals.

With the current system, a patient needs to attend a physician for a referral for physiotherapy. This creates an unnecessary expense and inconvenience. For example, rather than going to an emergency room because of a sprained ankle, individuals may be seen by a physiotherapist directly. The system would thus save time and money via the avoidance of the duplication of a very similar service.

Secondly, physiotherapists are very competent and highly trained health care professionals who provide an excellent service to the general public. In addition to four years of university training, our strong commitment to postgraduate education enables us to maintain and improve our ability to provide up-to-date and high quality care to our patients. We, as professionals, utilize evidence-based practice and research to provide as accurate and scientific an approach to treatment as possible.

As physiotherapists, we use an approach which includes the taking of a lengthy, subjective history and the performance of a detailed objective physical assessment to ensure the utmost of safety. Specifically, there are tests and evaluations that we use which are considered as warning signs to more serious conditions. If there are any concerns elucidated, we do not hesitate to contact the patient's physician to discuss and inform him/her of our findings.

The issue of direct access is becoming a standard across Canada. This bill would bring the physiotherapy profession in this province more in line with the rest of the nation.

Thank you for this opportunity.

Sincerely,
Paula Moreira
Yellowhead Physiotherapy and Athletic Centre
Neepawa, Manitoba

* * *

Letter for legislative committee reviewing Bill 26–The Physiotherapy Act

As a physiotherapist and physiotherapy researcher, I would like to submit a few important points regarding physiotherapy. The changes proposed in the new legislation for physiotherapy are in the best interest of the public, for government spending and for the physiotherapy profession.

Physiotherapists receive a minimum of four years of university education and earn a

Bachelor's degree upon completion of very intensive mainstream medical training. As well, in order to be trained to perform manipulation, postgraduate training is required. It takes two to three years of additional courses to learn peripheral joint manipulation and four to five years of course training and a competency examination to be trained to perform spinal manipulation. This treatment is not the sole technique used by physiotherapists, because rehabilitation is the focus of physiotherapy. Rehabilitation requires much more than one treatment method. It requires patient education, assessment and treatment. Indeed, this is what physiotherapists provide, successful treatment. In most cases of injury or pain, a quick fix does not exist. Through physiotherapy, patients are taught to become their own best therapist. This occurs through education in the management of their condition, rather than relying unnecessarily on a passive treatment which should only be used as an adjunct to the entire rehabilitation process.

The medical professions have demonstrated through medical research that the neuromuscular system is often the primary cause of pain or dysfunction rather than the joints alone. A physiotherapist is the only professional practitioner who has adequate training and skill to perform a complete orthopedic physical assessment and prescribe treatment, including patient education, exercise prescription and manual therapy. The research shows that the majority of spinal dysfunction and pain is due to the soft tissue structures and muscle balance rather than joint subluxation. Patients are often unnecessarily exposed to X-ray radiation for diagnosis when a true diagnosis can only be found through a full orthopedic assessment. Physiotherapists are trained in the medical system and learn about disease processes, the pathophysiology of disease and the abnormal and normal findings of a history and physical assessment. As medical professionals, physiotherapists have the knowledge and ability to judge when a patient's condition requires further medical investigation and readily refer onwards to their colleagues, the general physician, for consultation.

In my own practice, I have been called upon to assist many physicians in diagnosis and have detected abnormal disease processes through my assessment on at least four occasions. A general physician is a primary care professional, yet does not have an adequate knowledge base to perform an orthopedic assessment or prescribe treatment or exercise. Yet this does not make this professional unsafe because they are trained to refer to another professional who can provide assistance.

The cost saving of having direct access to physiotherapy services is an essential benefit to both the taxpayer and the government. By promoting direct access to physiotherapy services, as has been the case since the early 1980s, the number of emergency room visits should drop and cost of physician first contact visits would be reduced. Many conditions treated by physiotherapists do not require the input of a general practitioner. For example, a recreational athlete sprains an ankle playing slow-pitch on Saturday. They are able to walk but have swelling and pain. A visit to the physician, which may take two weeks to obtain unless the patient goes to emergency, is unnecessary in this case. Rather, the patient should seek attention from a physiotherapist who will assess and treat the sprain before it becomes a chronic problem.

Finally, physiotherapists are producing some of this province's best rehabilitation research to enhance the knowledge of rehabilitation professionals and to promote evidence-based practice. This trend will continue to proceed in the new millennium and the changes provided by the physiotherapy and continued quality research which will transfer into continued quality of care as has been the case thus far in the physiotherapy profession. Thank you.

Lynda Loucks, BMR, PT MSc(Rehab) candidate.

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Physiotherapy Act
Bill 26

Submission to the legislative committee
July 7, 1999

I would like to thank you for the opportunity to participate in this democratic process. Please

accept this submission on behalf of the Canadian Physiotherapy Association (CPA). As president of the Manitoba Branch of CPA, I represent 350 physiotherapists in Manitoba.

The Manitoba Branch of CPA would like to use this opportunity to clarify the areas of Bill 26 that have been challenged by the chiropractic profession.

Manipulation:

In their initial submission, the chiropractors challenged the right of physiotherapists to perform manipulations. However, they have since modified this position and they now accept that other health care providers, including physiotherapists, do have the right to manipulate. This change in position is not surprising since physiotherapists have had the legislative right to manipulate since its specific inclusion in The Physiotherapists Act in 1981. Physiotherapists have in fact been performing successful spinal and peripheral manipulations for many years. To date, there have been no injuries resulting from physiotherapy manipulative treatment. Further there have been no complaints lodged against any physiotherapists performing manipulation treatments.

In their modified position, the chiropractors have attempted to gain control over the "regulation" of manipulative treatment by insisting the procedure become a restricted activity. They also suggest the "stringent standards" of the chiropractic profession be imposed as the benchmark. This proposition implies that the current standards of the physiotherapy profession are not sufficient. If this were true, one would expect that unqualified, improperly trained physiotherapists would be inflicting harm on the public. The fact that there have been no injuries is a very strong reflection of the appropriate level of preparation and training physiotherapists receive. In fact the physiotherapy training and curriculum in manipulative manual therapy is certified and accredited by the International Federation of Manipulative Therapists (IFOMT). This international organization has set extremely high standards to ensure that all physiotherapists provide effective and safe manipulative treatment.

Public Access:

The chiropractors have questioned the ability of physiotherapists to perform differential diagnosis. They suggest that the change of wording from "diagnosis" to "assessment" is an admission of limited training. In fact the change in wording was at the recommendation of the Legislative Unit of Manitoba Health. The physiotherapy profession recognizes the implicit nature of the term "assessment" to reflect the inclusion of both subjective and objective information that leads to a differential diagnosis. In this context, the term "diagnosis" is more restricting and not reflective of the more comprehensive nature of the patient-physiotherapist interaction during an assessment. Further, the term "assessment" reflects the continuous process of evaluation of the physiotherapy intervention.

Physiotherapists receive comprehensive training in both undergraduate and postgraduate courses in the areas of assessment, differential diagnosis, clinical reasoning and problem solving. This solid academic and clinical base ensures that physiotherapists are able to establish an appropriate physiotherapy diagnosis based on the information gathered in the assessment process. Equally, this preparation provides the ability to recognize problems outside the physiotherapy scope of practice.

The practice of physiotherapy has always been an important part of mainstream medicine. Physiotherapists play a very active role in the health care team in the full continuum of health, from the management and prevention of injuries to the maintenance of health and quality of life for people of all ages. The provision of health care in the mainstream medical team means physiotherapists have very strong consultative relationships with the other health care providers. The citizens of Manitoba have had the opportunity of direct access to physiotherapists since 1981. There have been numerous consultative referrals initiated by physiotherapists for those patients who required the skills and knowledge of other health care providers (especially physicians) or those patients whose presenting complaints were beyond the scope of physiotherapy practice.

Liability:

Bill 26 addresses the concern expressed by the chiropractors regarding malpractice insurance. In the revised physiotherapy act, malpractice insurance will be mandatory for all physiotherapists. Currently the physiotherapists in private practice have acquired malpractice insurance because they do not enjoy the malpractice coverage offered in the public health institutions, such as hospitals. This is also in step with the historic reality that the true direct access to physiotherapy is only available in the private practice sector. Administrative requirements within public health care institutions require a physician to open a medical record.

The chiropractors have assumed the Association of Physiotherapists (APM), the licensing body for physiotherapists, would not be aware of any grievances or claims against physiotherapists without malpractice insurance. This is a false assumption. As a self-regulating profession, the APM is advised and involved in any lawsuit, grievance or complaint involving any physiotherapist practising in Manitoba. The mandate of APM is the protection of the public. The revised Physiotherapy Act will assist the APM in the investigation and disciplining of physiotherapists.

Public Opinion Survey:

The Manitoba branch of CPA conducted a comprehensive public opinion survey in May 1999. This telephone survey involved a statistically significant random sample of 500 Manitobans. There were 300 people surveyed in Winnipeg, and the other 200 were distributed throughout the remainder of Manitoba according to population.

In terms of the capability of health care practitioners, nurses and doctors followed by physiotherapists received the highest rating. Manitobans tend to be very pleased with their physiotherapist and the treatment they receive, and, in fact, very few (12 percent) expressed any degree of dissatisfaction.

Two thirds of the individuals who have had physiotherapy feel that their quality of life has been either somewhat or greatly improved as a result.

Summary:

Physiotherapists are safe and effective health care practitioners within mainstream medicine.

Physiotherapists have been using manipulation as a part of clinical practice with no injuries or complaints.

Bill 26 offers Manitobans easier access and a more cost-effective health care delivery system.

The revisions in Bill 26 ensure even greater protection for the public.

Thank you for this opportunity to make a presentation to the legislative committee on behalf of the 350 CPA members in the province of Manitoba.

Sincerely,

R. Neil MacHutchon (BMR-PT)
President, Manitoba Branch of CPA