

Strategic Solutions

*Optimizing Physiotherapists' Capacity in Ontario's
Health Care System*

Physiotherapy Scope of Practice Review 2008

*Submission to the
Health Professions Regulatory Advisory Council*

Submitted in partnership by:

**Ontario Physiotherapy Association
and
College of Physiotherapists of Ontario**

June 30, 2008

ONTARIO  PHYSIOTHERAPY ASSOCIATION



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EXECUTIVE SUMMARY

The Ontario government, in exercising its duty related to the delivery of a sustainable publicly funded health care system, has for some time been actively seeking innovative and strategic solutions that assure that quality, safety and efficiency are basic pillars to optimal health care for the public.

Physiotherapists, likewise, have been engaged in this dialogue at the grassroots contributing to new models of care, at the organization level championing interprofessional solutions, and at the systems level considering policy and standards that will support the broader needs.

Health human resources shortages factor across all debates and dialogue. Contributions by all stakeholders, all providers and the public themselves will assist in illuminating solutions to the key issues of:

- general access to primary care
- wait times for care
- the impacts of chronic disease, and
- the imperative of keeping a healthy public at home.

Physiotherapy, as a regulated profession in Ontario, is committed to the health care of Ontarians, and has a significant contribution to make. The profession supports HPRAC's principles that all solutions must embrace.

- responsibility to meet the public's expectations for improved access to high quality safe services and patient centred care;
- optimizing the contribution of all health professionals and
- a commitment to professional self regulation.

For a number of years the profession has been advocating for recognition of a scope of practice, and access to acts, that are reflective of physiotherapy education, competencies and practice activities. The current direction in Ontario means that the desire of the physiotherapy profession to better serve the population and health system by achieving recognition of its real capacity, is now aligned with the government's desire to support maximizing the potential of health professionals' scopes of practice and the implications that this has for enriching the interprofessional working environment.

Submission Context

The Ontario Physiotherapy Association (OPA) and the College of Physiotherapists of Ontario (the College) are pleased to respond to the Health Professions Regulatory Advisory Council's (HPRAC) review of the profession's scope of practice. The review reinforces government's and the profession's interests in promoting opportunities to expand and enhance interprofessional collaborative care by proposing ways in which physiotherapists' competencies can be used to their maximum.

The proposed model recognizes, leverages and utilizes physiotherapists' competencies across the continuum of services to public advantage and to benefit the current and future health system. The HPRAC request for input is timely in that proposed changes could make a significant difference now and in the future – for the population served, for system performance overall, for colleagues in interprofessional practice, and for physiotherapists' capacity to contribute to system reform. The physiotherapy profession welcomes the opportunity to partner with government in meeting health needs with innovative options.

Current Practice Environment

Physiotherapists are primary health care professionals practicing in all sectors of the system and across the continuum of care (paediatrics, geriatrics, palliative, acute etc.) As integral members of interprofessional teams they work collaboratively with other health providers, both regulated and unregulated, to deliver services within the profession's scope of practice and their particular individual competencies.

Physiotherapists have always contributed in a variety of roles within the health system dependent on need, as clinician, manager, educator, researcher, and/or consultant. Changes to delivery models have been met with responsiveness and flexibility by the profession. Expertise and specialty practice in a variety of settings have always been present and supported by ongoing post graduate and continuing professional development.

The past ten years have been a particular period of growth in innovative opportunities for physiotherapists to extend their competence within practice scope and contribute to system need. Often referred to as advanced practice roles, physiotherapists, under delegation protocols, are contributing to strategies related to reducing wait times, increasing access to specialty care, improving system triage for appropriate intervention, and increasing consumer satisfaction with health outcomes.

A Partnered Approach

The submission preparation was conducted as a partnership between the OPA, the College and the academic community. This tripartite group is known as the Ontario Physiotherapy Leadership Consortium (or OPLC). With the support of a research and writing team, the review involved careful consideration of data and evidence of current practice, combined with education (entry to practice and post graduate) and assessment. Methodology involved preliminary research and consultations with experts and advisors to update the picture of evolving physiotherapy practice. Results clearly pointed to the need for a more flexible approach to defining scope and authorized acts.

This body of knowledge reinforced the submission responses to HPRAC's questions, providing background information, evidence, rationale and examples. Appendices include the underlying research and jurisdictional scans that underpin and illustrate the context of practice evolution on which the proposed changes are based.

Seeking Change

The scope of practice and controlled acts within the existing *Physiotherapy Act* are not current and do not reflect the present entry to practice or post graduate education or practice roles. In order to better serve the public, the health system and to enhance the capacity of physiotherapists to positively contribute to interprofessional collaborative health teams, the physiotherapy profession is seeking several changes including those to the scope statement, to the available authorized acts and to the enabling elements of other statutory measures. The thrust of the changes align current physiotherapist competencies with current practice and promotes flexibility of the physiotherapy skill set to the advantage of health system transformation.

The submission also seeks to assist HPRAC in considering the future practice of the profession by identifying controlled acts currently performed by some physiotherapists in other jurisdictions and by

physiotherapists responding to critical public needs.

The proposed changes reflect national and international models, and the RHPA generally, which promotes flexibility, portability, ease of application and innovation at the point of care. The changes are coupled with appropriate accountability measures via the regulatory rigour of College standards and regulatory mechanisms related to controlled acts.

This submission advocates for the increased autonomy of physiotherapists within the scope of practice and respects individual competence. It promotes increased efficiencies by eliminating the need for medical directives where not warranted, and permits a physiotherapist to fully collaborate, using a proven skill set, with all health care providers to improve access to care and better outcomes for Ontarians.

Proposed Revisions

In summary, the major changes currently proposed include the following:

- **addition to the physiotherapy scope of practice to include the word ‘diagnose’**

Comparison of Current and Proposed Scope of Practice for Physiotherapists in Ontario	
<p>Current: The practice of physiotherapy is the assessment of physical function and the treatment, rehabilitation and prevention of physical dysfunction, injury or pain, to develop, maintain, rehabilitate or augment function or to relieve pain.</p>	<p>Proposed: The practice of physiotherapy is the assessment of neuromuscular, musculoskeletal and cardiorespiratory systems to:</p> <ol style="list-style-type: none"> 1. diagnose, treat and prevent disorders or diseases that cause or are associated with physical dysfunction, injury and/or pain; 2. develop, maintain, rehabilitate or augment function; 3. relieve pain; or 4. promote mobility and health.

- **authority for an additional five controlled acts or components of controlled acts** for all physiotherapists with demonstrated competencies:
 1. Communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person’s symptoms.
 2. Treating a wound including by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.
 3. Administering, by inhalation:
 - i. oxygen, or
 - ii. a drug or substance that has been ordered by person who is authorized to do so by the *Chiropody Act* 1991, the *Dentistry Act*, 1991, the *Medicine Act*, 1991 the *Nursing Act*, 1991 or the *Midwifery Act*, 1991.
 4. Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment or treatment.

5. Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder,
 - i. the application of electromagnetism for magnetic resonance imaging, and
 - ii. the application of sound waves for diagnostic ultrasound.
 - **removal of limitations in other statutory provisions**, to enable ordering of important resources and activities (by physiotherapists with appropriate demonstrated competence), including the most significant:
 - Ordering x-rays: requires changes to the *Healing Arts Radiation Protection (HARP) Act*
 - Ordering laboratory investigations: requires changes to the *Laboratory and Specimen Collection Centre Licensing Act*; and
 - Initiating or ordering treatment or diagnostic procedures in a hospital: requires changes to the *Public Hospitals Act*.
 - Referral to specialty medicine requires changes to the *Health Insurance Act* as well as the removal of the requirement of referral for physiotherapy services within this Act.

Public Protection

The proposed changes are reinforced by accountability measures set by the College in standard and regulatory programs. A controlled acts standard sets the bar for physiotherapists in their performance expectations, including the key elements of education. Registration processes require annual reporting of controlled acts performed in practice. The professional misconduct regulation states clearly that performance of a controlled act must only occur where requisite knowledge, skills and abilities are all in place. And, finally, the practice assessment component of the quality management program affords an on site peer review of actual performance.

Opportunities to increase the regulatory rigour to meet increased authorities for physiotherapists exist, such as rostering physiotherapists on the public register in relation to controlled acts performed. The profession, through the College, is well positioned to respond.

Future Considerations

Within the review HPRAC asked the profession to consider future roles.

The research on controlled acts and physiotherapist competence incorporated this view and did reveal activities embedded in other jurisdictions that are beginning to emerge in Ontario. In particular, additional acts that may warrant further discussion include:

- setting or casting a fracture of a bone or dislocation of a joint
- applying or ordering the application of electricity for electromyography and nerve conductive studies.
- prescribing medication, but more particularly medication management after initial ordering.

Opportunity to follow the development of physiotherapists' performance of these controlled acts under delegation and their impact on care delivery models will be important to ensure an open and transparent process by which scope can continue to appropriately evolve.

Concluding Rationale

The thrust of the proposed changes is aimed at enabling physiotherapists to function to their fullest individual competency, as stronger interprofessional, collaborative partners.

The proposed changes will enhance and expand public access to appropriate care, and contribute significantly to the productivity of other health professionals with whom the profession collaborates across the continuum, boosting overall system performance.

The profession believes this suggested approach to matching physiotherapy current practice and competencies to a modernized scope statement and controlled acts authorization is best for the public, providers and the system. It represents an important opportunity for physiotherapy to assist government and health care employers to improve health outcomes, and to improve health system performance in serving population needs.

The profession looks forward to discussing this submission with HPRAC and is committed to be a willing player in all dialogues or potential options that will realize the fullest contribution that physiotherapists can make to collaborative, patient-centred care.

Section 1 - Introduction

The Ontario Physiotherapy Association (OPA) and the College of Physiotherapists of Ontario (the College) are pleased to provide this submission, *Optimizing Physiotherapists' Capacity in Ontario's Health Care System* and offer strategic solutions in response to the April 2008 invitation of the Health Professions Regulatory Advisory Council (HPRAC). The OPA and the College appreciate the chance to provide input to the HPRAC review of the current scope of practice of physiotherapists. The review reinforces government's interests in promoting opportunities to improve and enhance interprofessional collaborative care through optimizing the contributions of all health professions.

The goal of this submission is to present evidence underpinning the profession's request to modernize the physiotherapy scope of practice and permit access to a number of additional authorized acts so that the reality of physiotherapy knowledge, competence, and practice will be recognized and supported. This will position physiotherapists to better serve the public, offer more to other health professionals in collaborative practice, and to improve health system efficiency and effectiveness.

The submission builds on the examples of advancement in physiotherapy practice over the past twenty years and the widespread interest among physiotherapists to achieve recognition of the profession's practice today. There have been persistent and consistent efforts to achieve adjustments to the scope of practice, beginning during the development and emergence of the RHPA¹, submissions in 1999, 2001, and more recent comprehensive reviews and efforts beginning in 2005. The profession came together in a May 2006 Evolving Physiotherapy Practice Forum², to explore the issues and options around health system reforms with an aim to optimizing patient health outcomes and overall system performance.

The development of the submission was conducted as a partnership between the OPA, the College and the academic community, known as the Ontario Physiotherapy Leadership Consortium (or OPLC). With the support of a research and writing team, the review involved careful consideration of data and evidence of current practice, combined with education (entry to practice and post graduate) and assessment. Methodology involved preliminary research and consultations with experts and informants, to update the picture of evolving physiotherapy practice. Results clearly pointed to the need for a more flexible approach to defining scope and authorized acts.

This body of knowledge reinforced the submission responses to HPRAC's questions, providing background information, evidence, rationale and examples. Appendices include the underlying research, jurisdictional scans that underpin and illustrate the context of practice evolution, and standards on which the specific changes proposed are based.

Section 2- Profession Information [Questions 1-8]

1. Does your current scope of practice accurately reflect your profession's current activities, functions, roles and responsibilities?

No. The evolution of the practice and education of physiotherapists over the past several decades has resulted in an array of competencies that are regularly performed, yet many are not authorized under the *Physiotherapy Act*. More specifically with respect to the current scope of practice statement, the absence of the word "diagnose" is most notable.

¹ RHPA 1991

² College of Physiotherapists of Ontario 2006

Physiotherapists have been trained and are fully competent to formulate diagnoses within the physiotherapy scope of practice and the profession's essential competencies for practice in all areas. Physiotherapists routinely formulate diagnoses in order to devise treatment plans and to communicate with referring practitioners and other members of the health care team.

The absence of a reference to diagnosis in the physiotherapy statutory scope of practice statement has impacts at point of care, delaying treatment, complicating interprofessional interactions and confusing third party payors who expect a diagnosis from health professionals, including physiotherapists, as a prerequisite of payment.

Transparently recognizing the scope of the profession in relation to its proven competencies will assist with clarity for the public, other health providers, and all health care funders

If the answer to question #1 is no, then please answer the remaining questions (only those that apply) as thoroughly as possible:

2. Name the profession for which a change in scope of practice is being sought and the professional act that would require amendment

Profession: Physiotherapy
Act: *The Physiotherapy Act, 1991*

3. Describe the change in scope of practice being sought

In summary, the major changes proposed include the following:

- **revisions to the physiotherapy scope of practice** to include the word 'diagnose' as well as to provide some additional clarity relating to the body systems that physiotherapy practice includes:
- **authority for five additional controlled acts** for physiotherapists
 1. Communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person's symptoms.
 2. Treating a wound including by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.
 3. Administering, by inhalation:
 - i. oxygen, or
 - ii. a drug or substance that has been ordered by person who is authorized to do so by the *Chiropody Act 1991*, the *Dentistry Act, 1991*, the *Medicine Act, 1991* the *Nursing Act, 1991* or the *Midwifery Act, 1991*.
 4. Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment, diagnosis or treatment.
 5. Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder,

- iv. the application of electromagnetism for magnetic resonance imaging, and
 - v. the application of sound waves for diagnostic ultrasound.
- **removal of limitations in other statutory provisions**, to enable ordering of diagnostic tests and activities (by physiotherapists with appropriate demonstrated competence), including the most significant:
 - Ordering x-rays: requires changes to the *Healing Arts Radiation Protection (HARP) Act*
 - Ordering laboratory investigations: requires changes to the *Laboratory and Specimen Collection Centre Licensing Act*; and
 - Ordering treatments or diagnostic procedures in a hospital: requires changes to the *Public Hospitals Act*.
 - Referral to specialty medicine requires changes to the *Health Insurance Act* as well as the removal of the requirement of referral for physiotherapy services within this Act.

The proposed changes are reinforced by accountability measures articulated in College standards and regulatory mechanisms related to controlled acts. Please see question #12 for further detail and an overview of the proposed changes.

4. Name of the College/Association/group making the request, or sponsoring the proposal for change, if applicable

Ontario Physiotherapy Association (OPA)

College of Physiotherapists of Ontario (the College)

5. Address/website/e-mail

Ontario Physiotherapy Association
55 Eglinton Ave East, Suite 210
Toronto, ON M4G 1G8
www.opa.on.ca

College of Physiotherapists of Ontario
375 University Avenue, Suite 901
Toronto, ON M5G 2J5
www.collegept.org

6. Telephone and fax numbers

Ontario Physiotherapy Association
Telephone: 416-322-6866
Fax: 416-322-6705

College of Physiotherapists of Ontario
Telephone: 416-591-3835
Fax: 416-591-3834

7. Contact person (including day telephone numbers)

Dorianne Sauvé, Chief Executive Officer
Ontario Physiotherapy Association
Tel: 416-322-6866 ext. 226
Email: dsauve@opa.on.ca

Jan Robinson, Registrar and Chief Executive Officer
College of Physiotherapists of Ontario
Tel: 416-591-3828 or 1-800-583-5885, ext. 252
Email: jrobinson@collegept.org

8. List other professions, organizations or individuals who could provide relevant information applicable to the proposed change in scope of practice of your profession. Please provide contact names, addresses and contact numbers where possible.

Academic Chairs of Physiotherapy University Programs of Ontario

McMASTER UNIVERSITY

Contact: Dr. Laurie Wishart, Assistant Dean

Physiotherapy Program,
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1400 Main Street West
Hamilton, ON L8S 1C7
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QUEEN'S UNIVERSITY

Contact: Dr. Kathleen Norman, Chair

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UNIVERSITY OF OTTAWA

Contact: Dr. Francois Tremblay, Director

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UNIVERSITY OF TORONTO

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Tel: 416-946-8641
Fax: 416-946-8562
Email: pt.reception@utoronto.ca
Website: www.physicaltherapy.utoronto.ca

UNIVERSITY OF WESTERN ONTARIO

Contact: Dr. Jayne Garland, Director

School of Physical Therapy
Faculty of Health Sciences
Arthur and Sonia Labatt Health Sciences Building,
Room 200, London, ON N6A 5B8
Tel: 519-661-2111
Website: www.uwo.ca/fhs/pt

The Canadian Physiotherapy Association

(this would include all provincial, national and international physiotherapy associations)

Contact: Dawn Burnett, Director Practice and Policy

1400 Blair Place, Suite 205
Ottawa, ON K1J 9B8
Phone: 613-564-5454, x2222 or 1-888-474-9746
Fax: 613-564-1577
E-mail: dburnett@physiotherapy.ca

Canadian Alliance of Physiotherapy Regulators (The Alliance)

(this would include all provincial physiotherapy regulators)

Contact: Joseph Vibert, Chief Executive Officer

1243 Islington Avenue, Suite 501
Toronto, ON M8X 1Y9
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Fax: 416-234-8820
Website: <http://www.alliancept.org/>

Accreditation Council for Canadian Physiotherapy Academic Programs

Contact: Cathryn Beggs, Executive Director

509 Commissioners Road West, Suite 26
London, ON N6J 1Y5
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Email: info@accpap.ca
Website: <http://www.accpap.ca>

Section 3 - For Associations

[Questions 9-11]

9. Names and positions of officers and directors

Mark Beadle, President, Ontario Physiotherapy Association

Lori Neill, President, College of Physiotherapists of Ontario

10. Length of time the association has existed as a representative organization for the profession

The Ontario Physiotherapy Association was incorporated in 1964 as the provincial professional association for physiotherapists and the provincial Branch of the Canadian Physiotherapy Association (CPA) in Ontario. Prior to that time the Association had existed as a non-incorporated Branch of the CPA which has had a presence in Ontario since the 1920's.

The College of Physiotherapists of Ontario was proclaimed in statute December 31, 1993. Previously it existed as the Board of Directors of Physiotherapy under the Drugless Practitioners Act from 1954 until 1993.

11. List name(s) of any provincial, national or international association(s) for this profession with which your association is affiliated or who have an interest in this application. Please provide contact names, addresses and contact numbers where possible.

See Question 8

Section 4 - Legislative Changes

[Questions 12-13]

12. What are the exact changes you propose to the profession's scope of practice (scope of practice statement, controlled acts, title protection, harm clause, regulations, exemptions or exceptions that may apply to the profession, standards of practice, guidelines, policies and by-laws developed by the College, other legislation that may apply to the profession, and other relevant matters)? How are these proposed changes related to the profession and its current scope of practice?

In summary, this submission seeks a change in the physiotherapy scope of practice, along with authority for five new controlled acts and other statutory changes to remove key barriers to practice. Changes are supported by regulatory infrastructure found in College standards and programs. Each proposed change is reviewed in more detail below. The submission also points out future potential options for consideration over time.

Currently Proposed Changes

The major thrust of the currently proposed changes is to enable all physiotherapists to function to their fullest individual competency, within the scope of practice of the profession, as strong interprofessional partners in care, by including essential areas of authority within statute and removing barriers and limitations.

This proposed model does not abandon the concept of advanced practice roles for physiotherapists; rather, these roles are facilitated by a flexible and more system responsive approach, by authorizing

the controlled acts to physiotherapists who have met the standard and regulatory requirements of the College to perform them. This allows the roles to be tailored to the local patient and system needs rather than being bound by a separate class through registration that cannot be altered easily as the system evolves. This approach is in keeping with the national and international trends in the area of advanced or extended practice. In addition this approach is familiar to the profession as it retains exactly the same model for performing controlled acts as currently exists. A physiotherapist would only be able to perform the controlled acts authorized to the profession in accordance with professional standards of practice.

Our regulatory proposal includes:

- **Physiotherapy scope of practice**

The first amendment proposed is to include the word “diagnose” along with some refinement of the scope statement to clarify and align it with more recently constructed scope statements for some other regulated professions by being more descriptive and explicit about the body systems that physiotherapists address. The table below compares the current and proposed scopes.

Comparison of Current and Proposed Scope of Practice for Physiotherapists in Ontario	
<p>Current: The practice of physiotherapy is the assessment of physical function and the treatment, rehabilitation and prevention of physical dysfunction, injury or pain, to develop, maintain, rehabilitate or augment function or to relieve pain.</p>	<p>Proposed: The practice of physiotherapy is the assessment of neuromuscular, musculoskeletal and cardiorespiratory systems to:</p> <ol style="list-style-type: none"> 1. diagnose, treat and prevent disorders or diseases that cause or are associated with physical dysfunction, injury and/or pain; 2. develop, maintain, rehabilitate or augment function; 3. relieve pain; or 4. promote mobility and health.

The proposed scope statement would be applicable to all physiotherapists registered with the College. The changes reflect the current practice of physiotherapists and affirm the capacity of physiotherapists to diagnose within their scope of practice enabling them to practice to the full extent of their individual competencies.

Within this statement, the most significant proposed change is the addition of the word ‘diagnose.’ The intention is to make it clear that diagnosis is an activity that should be reflected in the statutory scope of practice for physiotherapy. It represents a core element of physiotherapy practice, critical to serving population needs. It is taught and tested in physiotherapy educational programs as an expected entry to practice competency for physiotherapists.

Including diagnosis in the scope statement also supports the request (below) for the authority for physiotherapists to perform the controlled act of ‘communicating of a diagnosis.’ The change would

bring Ontario in line with all other Canadian provincial jurisdictions and selected countries reviewed for this submission, affirming 'diagnosis' as part of expected entry to practice physiotherapy practice and legislation.

Other material changes include the addition of reference to explicit body systems, neuromuscular, musculoskeletal and cardiorespiratory. This clarifies the nature of physiotherapists' treatment and its core components, and aligns the phrasing with that used by other regulated health professions, such as chiropractic, massage therapy, nursing and occupational therapy.

The addition of explicit language to "promote mobility and health" articulates an emphasis in physiotherapy on important public and systemic needs and aims regarding wellness and health promotion, whether services are provided in institutions, the community or in a primary health care setting.

Additional Controlled Acts

The current *Physiotherapy Act* contains two authorized acts:

- Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust; and
- Tracheal Suctioning.

This proposal seeks changes to the *Physiotherapy Act* for five additional controlled acts, as summarized below. All of the proposed additional authorized acts are within the scope of practice of physiotherapy. They would apply to physiotherapists with demonstrated competence, in keeping with the legislation and as regulated by the College's standards of practice, including its Standard for Professional Practice – Performing Controlled Acts. In this way the model is similar to medicine, where all physicians are authorized to perform controlled acts, as regulated by their College, but only if they have the competence to do so.

This proposed change supports the increasingly numerous advanced practice roles for physiotherapists throughout the province facilitating a flexible and more system responsive approach. It allows roles to be tailored to the local patient and system needs rather than being bound by registration classification that cannot be altered easily as the system evolves. In addition this approach is familiar to the profession as it retains exactly the same model for performing controlled acts as currently exists. A physiotherapist can only perform any of the controlled acts authorized to the profession in accordance with professional standards of practice.

Communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person's symptoms.

All physiotherapists are educated to diagnose and communicate a diagnosis related to physical diseases or disorders to their patients or their patients' personal representatives at the entry to practice. It is a fundamental and important aspect of entry to practice physiotherapy practice.

The review of evidence suggests that physiotherapists have competent diagnostic skills and that are evaluated in a number of ways including the national Physiotherapy Competency Examination.

Approval of this authorization will bring Ontario in line with all other Canadian and the many other international jurisdictions where physiotherapists are expected to develop and communicate a

diagnosis at the entry to practice of physiotherapy practice.

Treating a wound including by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.

This represents a subcomponent of the controlled act of performing procedures below the dermis. Wound care is part of physiotherapy practice. Wounds are often seen with those with chronic illnesses such as diabetes and those with poor mobility. Care is provided in all settings including acute care, long term care and home care. Physiotherapists receive base education on wound care, modalities to speed healing and positioning in entry to practice education programs. Additional training post graduate is available for those who specialize in this area of practice. Further detail regarding practice and education is available in Appendix A. Many other provinces are currently authorized to practice in this area. The Atlantic provinces are already in position for the physiotherapy college to regulate once the practice is initiated. (see Question 32)

Administering, by inhalation:

- i. **oxygen, or**
- ii. **a drug or substance that has been ordered by person who is authorized to do so by the *Chiropody Act 1991, the Dentistry Act, 1991, the Medicine Act, 1991 the Nursing Act, 1991 or the Midwifery Act, 1991.***

This represents a sub-component of the controlled act of administering substances by injection or inhalation. In response to an authorized order, physiotherapists will have authority to administer oxygen and substances such as Ventolin when required as a part of a physiotherapy intervention. The review of the evidence supports this as an area that is taught and evaluated at the entry to practice and is identified in the current Analysis of Practice in Canada³ (2008). Currently, it is practiced under medical directive/delegation. (see Appendix A). Ontario is the only province where this activity is managed under supervision and a medical directive. (see Question 32).

In most other provinces physiotherapists are currently authorized to practice in this area. In the case of the Atlantic provinces the physiotherapy colleges are able to regulate once the practice is initiated. Ontario is the only province where this activity is managed under supervision and a medical directive. (see Question 32 and Appendix E)

As a further example in Ontario, physiotherapists currently have authority to perform tracheal suctioning which normally requires the administration of oxygen. In this context, the lack of authority to administer oxygen to maintain oxygen saturation, particularly in the context of tracheal suctioning of intubated patients, has presented a challenge to physiotherapists. As oxygen de-saturation often occurs with activity, the administration of oxygen during physiotherapy interventions related to increasing exercise tolerance and mobility to maintain saturation is critical to care.

Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment or treatment

The principal reason for proposing that physiotherapists be authorized to perform this act is in relation to the management of incontinence. Incontinence may occur as a consequence of neuromuscular disorders or in women post-partum. However, it is also associated with obesity and age-related changes, including in men, and therefore the demand for services in Ontario is growing. Assessment

3 Canadian Alliance of Physiotherapy Regulators 2008

of incontinence includes evaluation of the status of the pelvic floor musculature, and treatment may include a focus on strengthening these muscles. These procedures may therefore require insertion of a finger or instrument to evaluate muscle contraction, to provide feedback to patient regarding muscle contraction (e.g., biofeedback) or to stimulate muscle contraction (i.e., through electrical stimulation devices specifically designed for this application). The other reason for proposing that physiotherapists be authorized to perform this act is so that physiotherapists who have competency at spinal manipulation – i.e., a controlled act already authorized to physiotherapists in Ontario – are able to perform manipulation of the lowest part of the spinal column, the coccyx.

In entry to practice education, physiotherapists gain knowledge about relevant anatomy, and causes and presentation of incontinence and related disorders, and they gain knowledge and skills in the application of techniques of muscle re-education. They are thus well-positioned to gain competency at the remaining component – i.e., the proposed controlled act itself – in short post-graduate courses (see Appendix A for related information). In most Canadian provinces, physiotherapists are permitted to perform this procedure as within scope (see Appendix E). Physiotherapists in Ontario currently performing this procedure do so under medical directive/delegation models, however, as much of this care is sought in community settings many patients go untreated or are referred back to family physicians and onto specialty medical care.

Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder,

- i. the application of electromagnetism for magnetic resonance imaging, and**
- ii. the application of sound waves for diagnostic ultrasound.**

This is intended to give physiotherapists the authority to order MRI's and diagnostic ultrasounds. There is no intent to grant authority to apply these forms of energy. The defined purpose of this authorization is to support physiotherapists' diagnosis, in particular in advanced roles.

Physiotherapists' entry to practice training includes an introduction to the indications, contraindications and interpretation of MRI and diagnostic ultrasound. However, consultation clearly indicates that post-graduate training is required to achieve the knowledge to have the competency to order MRI or diagnostic ultrasound. Currently there are physiotherapists with demonstrated competence ordering these diagnostic tests under medical directive/delegation in Ontario. Post graduate programs are available in Ontario. In-house training exists in some institutions such as the Ottawa Hospital and the Holland Orthopaedic and Arthritic Centre. See Appendices A and B for more details regarding education programs.

Nationally, physiotherapists in British Columbia may order diagnostic ultrasound and Alberta intends to pursue authorization to order MRIs and Diagnostic Ultrasound. Manitoba is pursuing authorization with a priority for underserved areas of the province. Further detail on the jurisdictional review is available in the response to Question 32.

Proposed Other Statutory Changes

Changes to a number of other acts are proposed in order to permit physiotherapists to work to the full range of their competence within their scope and remove barriers from doing so. As supported by a competency-based rationale and demonstrated experiences, these changes will permit physiotherapists to:

- **Order x-rays**

Changes to the *Healing Arts Radiation Protection Act (HARP)* and related regulations are required to enable physiotherapists to order x-rays. This is in keeping with requesting the authorization to order MRI and diagnostic ultrasound to enhance physiotherapists' capacity to diagnose within scope. Physiotherapists must be able to choose the most appropriate imaging technique to assess the presenting symptoms of patients.

Physiotherapists' entry to practice training includes anatomy and an introduction to the indications and contraindications of x-rays. This positions physiotherapists well for post-graduate training in this area of imaging diagnostics. Such training is present in Ontario and is expanded on in Appendix A.

Many physiotherapists with demonstrated competence in this area are working under medical directive/delegation in areas such as Ottawa, Hamilton, Kingston and the Greater Toronto Area, for example, to evaluate and follow up patients with arthritis or in out-patient clinics.

In the area of spinal manipulation, physiotherapists have access to extensive training and defined curriculum through professional development (e.g. Orthopaedic Division of the Canadian Physiotherapy Association) and post graduate university programs (e.g. Masters of Clinical Science in Manipulative Therapy, University of Western Ontario). Physiotherapists are taught the indications and contraindications regarding spinal manipulation and when it would be appropriate to order an x-ray to rule out other issues or contraindications for manipulation.

The specific changes to the *Healing Arts Radiation Protection Act (HARP)* and the regulations under the Act needed to enable physiotherapists to order x-rays include the following:

1. In Sections 5(2) and 6(1) of the Act, the addition of physiotherapists to the list of persons who are permitted to order x-rays.
2. In Section 6 of the Act, the addition of a clause specifying the areas of the body upon which a physiotherapist can order x-rays. The wording proposed that physiotherapists could order x-rays for the irradiation of the chest, the ribs, the spine (including the cervical, thoracic and lumbar spine), the shoulder, the elbow, the wrist, the hand, the pelvis, the hip, the knee, the leg, the ankle or the foot of a human being.

- **Order laboratory tests**

Changes to Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* are required in order to enable physiotherapists to order laboratory investigations to enhance the ability of physiotherapists competent at an advanced level to diagnose and to support triage of patients.

Physiotherapists' entry to practice training provides theory regarding indications and interpretation for some laboratory tests such as inflammatory markers related to inflammatory arthritis and nutritional status and its impact on wound care and healing. However, consultation with experts indicates that post-graduate training is required in order to acquire the competencies necessary to order lab tests safely and effectively.

A number of physiotherapists with demonstrated competence in this area are ordering laboratory tests including the complete blood count (CBC), erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) under medical directive/delegation in a number of centres (e.g. Ottawa, Kingston, Hamilton and greater Toronto). Formalized training is available through the several educational programs. In addition, some institutions provide in-house training.

The specific changes to Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act* needed to enable physiotherapists to order appropriate laboratory investigations include:

1. Changes to Section 9 of Regulation 682 to permit owner/operators of laboratories to examine specimens that were taken at the request of a physiotherapist.
2. Changes to the appendices of Regulation 682 develop a new appendix (Appendix D) that will define the laboratory tests that physiotherapists can order. This list of proposed tests includes:
 - Complete blood count (CBC)
 - C-reactive protein (CRP)
 - Erythrocyte sedimentation rate (ESR)
 - Rheumatoid factor (RF)
 - Antinuclear antibodies (ANA)
 - Glucose (quantitative)
 - Transthyretin (TTR) (prealbumin)

- **Permit physiotherapists to provide or order treatment in a hospital**

A number of changes to the regulations under the *Public Hospitals Act* are needed to enable physiotherapists to provide or order treatment in a hospital.

Among the changes are following:

1. The Hospital Management Regulation, Regulation 965, under the *Public Hospitals Act* will need to be amended to permit physiotherapists to register persons as hospital outpatients (Section 11).
2. The Hospital Management Regulations, Regulation 965, under the *Public Hospitals Act* will need to be amended to permit physiotherapists to initiate and order treatments and diagnostic procedures (Section 24) within the hospital.
3. The Hospital Management Regulations, Regulation 965, under the *Public Hospitals Act* will need consequential amendments in terms of definitions and the duties that would be required of physiotherapists in defined circumstances (infectious patients, records, etc).

- **Permit regulated health professionals to act on the order of a physiotherapist**

Changes would be required to a number of profession specific acts for regulated health professions in the sections that define additional requirements for them to perform their authorized acts in order to permit them to perform these procedures when they are ordered by a physiotherapist

The acts that need revision in this context are:

1. *The Medical Radiation Technology Act*, Section 5
2. *The Medical Laboratory Technology Act*, Section 5
3. *The Nursing Act*, Section 5,
4. *The Respiratory Therapy Act*, Section 5

- **Permit physiotherapists to refer to appropriate specialists for medical care**

Changes to the *Health Insurance Act* are needed to amend the current provisions of the Act that limit the ability of specialist physicians to accept referrals from physiotherapists.

Currently physiotherapists, including those in advanced roles, are unable to refer a patient directly to the appropriate specialist for medical care. The requirement in the *Health Insurance Act* for a medical referral to initiate payment for that specialized service limits the flexibility of the system to use the available health human resources to the maximum to relieve pressures within the health system such as increased wait times.

- **Permit public access without physician referral to physiotherapists billing OHIP**

Changes to the *Health Insurance Act* are needed to amend the current provisions requiring a physician referral to access public funded physiotherapy services through a designated physiotherapy clinic.

The current requirement for a physician referral to access physiotherapy services through designated physiotherapy clinics presents an unnecessary barrier to the public and places strain on limited health human resources in requiring additional physician visits to access needed care.

Title protection

No changes are proposed in this area.

Harm Clause

No changes are proposed in this area. Please see further discussion of this subject at Question 20.

Regulatory Rigour and Public Protection: Standards and Competencies

As indicated earlier, a registrant who performs authorized acts does so only when appropriate, according to the need and individual competencies. In this way, the approach taken in the medical profession serves as a model. For example, while there are 12 controlled acts that physicians may perform, all physicians generally do not perform all of the acts. Physicians perform those acts most relevant to their individual competence and education, patient needs, and practice realities.

In this approach, any performance of a controlled act by a physiotherapist must meet the Standard of Practice set by the College. This standard notes that registered physiotherapists may perform a controlled act or a component of a controlled act when they are acting within the scope of practice of physiotherapy and:

- the patient's assessment results warrant the performance of the act,
- they are authorized to perform it,
- they are competent to perform it,
- they are able to manage the reasonably foreseeable outcomes related to the performance of the controlled act,
- they accept personal accountability for the performance of the act, and
- they meet any other statutory, regulatory and professional responsibilities that apply.

The standard also contains specific expectations as to how they should obtain the needed competencies to perform controlled acts. Physiotherapists will need to be able to demonstrate successful completion of educational programs that have the following components:

- a structured theoretical component that includes information on the indications,

- contraindications and risks associated with the performance of the controlled act(s);
- a practical component that includes both information on the technical performance of the controlled act and an opportunity to perform the controlled act(s) under supervision; and
- an assessment method that evaluates theoretical and practical knowledge associated with the safe and competent performance of the controlled act(s).

The standard also includes an expectation for registrants to maintain their competence through continuing education programs that include updated theoretical and practical knowledge.

A framework of current and additional regulatory mechanisms to ensure continuing competence and safe care will include:

- an annual registration declaration on which controlled acts the physiotherapist is performing (current);
- a requirement to report post graduate education achieved related to the relevant controlled act (new);
- an opportunity to roster on the public register physiotherapists performing particular controlled acts (new)
- adherence to the professional misconduct regulation which defines misconduct as, among other things, “failing to maintain the standards of practice of the profession” (current);
- adherence to the professional misconduct regulation which will add an additional definition of misconduct as “performing a controlled act that was delegated to the member by another person unless the member has the knowledge, skills and judgement to perform the controlled act” (new); and
- random practice assessments of those physiotherapists performing controlled acts in keeping with the current QM program (new).

Consideration of the practice evolution

The profession also considered HPRAC’s request for the profession to think about the continuing evolution of practice. This consideration identified three further areas where the profession may need at some point to obtain authority to perform additional controlled acts over and above those discussed above. The three areas identified for future consideration are:

- Setting or casting bone fractures or joint dislocations,
- Applying or ordering the application of electricity for purposes such as electromyography and nerve conduction studies, and
- The management of medication after it has been initially prescribed.

Further detail on these activities is provided in the profession’s response to Question 35.

13. How does current legislation (profession-specific and/or other) prevent or limit members of the profession from performing to the full extent of the proposed scope of practice?

Current legislation, such as the *Physiotherapy Act*, the *Healing Arts Radiation Protection Act (HARP)*, the *Laboratory and Specimen Collection Centres Licensing Act* and the *Public Hospitals Act* as main examples, places limitations on physiotherapists (by requiring alternative authorization or additional health professions to be involved in care) from responding to the system and performing to the full extent of their competencies and scope.

These statutes currently limit:

- the communication by physiotherapists of a diagnosis derived from a physiotherapy assessment to a patient under their care
- the administration by physiotherapists of oxygen and/or medication by inhalation, when ordered for a patient, when the administration of oxygen to maintain oxygen saturation and or medication is required as part of a physiotherapy program or intervention such as suctioning or a conditioning/exercise program as examples
- timely access by the public to physiotherapists trained to perform wound care and treatments shown to be effective in wound healing to perform these interventions
- timely access by the public to incontinence care for women and men by physiotherapists trained to perform these assessment and intervention procedures
- the profession's ability to be responsive to evolving health system needs such as wait time pressures in areas such as ordering of diagnostic tests (magnetic resonance imaging, ultrasounds), x-rays and lab tests necessary to maximize the impact of collaborative triage, assessment and outreach roles for physiotherapists

Physiotherapists' education, training and experience make them competent to perform a much greater range of activities than are included within the current scope of practice. The options they face under the current legislative environment to deal with the limitations include:

- Alternate authorization such as medical directives/delegations/orders: These alternatives are beneficial when they represent initial evolutions of a profession's scope. When the competencies to perform the act safely and within the principles of autonomous practice exist, then the alternate authorizations become an unnecessary limitation on the scope of a profession. The alternate authorizations further limit timely access to needed health care interventions by adding additional steps and barriers, by requiring additional health professions to be involved in care at a time when health human resources are strained and negatively affects potential system efficiencies that can be attained when health professions are used to the maximum of their skills and competencies.
- Referral to another health profession such as a physician or specialist in order to assist the patient in accessing a diagnosis or to request an order or referral from the physician for the diagnostic tests requested by the physiotherapist or to request an order or referral back to the physiotherapist in order to initiate a treatment that is within the competencies and skills of the physiotherapist.
- Not performing the intervention and potentially eliminating patient access to service, particularly in rural care

Further, despite system aims for responsiveness to population needs, physiotherapists face a range of limitations on practice that expose issues for the public and the system. As expressed by members of the profession and as documented in the literature^{4,5}, such limitations include:

Compromised Public Access:

- Needed care may be delayed - for certain acts, the physiotherapist cannot immediately respond to communicate about or act on functions involving controlled acts not currently authorized.
- In the absence of being authorized to communicate a diagnosis, the process of obtaining

4 HPRAC 2008

5 Cott et al 2007

informed consent is more complicated. The public expects a diagnosis from a health professional and have no understanding of terms such as 'clinical impression.' Trust and belief in the skills and knowledge of the health professional is an important component of successful outcomes.

- Access to services is encumbered by the requirement to take or repeat extra steps to see other authorized providers (i.e. to receive an order or delegation to receive incontinence assessment and treatment) to satisfy authorized procedures.
- Accessing funding for treatment from third party insurers who require a diagnosis can be delayed.
- Transparency of authority and accountability to patients is reduced by delegation, as protocols/directives are not in the public domain and vary from institution to institution.

Constraints on System Performance:

- The presence of alternate authorizations such as directives, where unnecessary, limits physiotherapists' ability to participate fully in interprofessional collaborative practice as they:
 - contribute to a lack of clarity and understanding in the workplace of physiotherapists' roles, accountability, scope and competencies
 - lead to underutilization of the profession
 - are not transportable
 - create regulatory complexities
- Delays and costs associated with setting up, maintaining and changing directives which may be unnecessary given physiotherapists' competencies, this constraint is particularly felt in health care delivery venues where no medical directives exist (e.g. community clinics, home care, industry, rural/remote and other under-serviced areas). Challenges include:
 - lengthy processes to develop appropriate delegation protocols or medical directives, specific to individual settings
 - problems with changing authorizers and the need to keep directives current
 - problems in finding appropriate delegators/authorizers in community practice (or the absence thereof, e.g. in rural and remote areas)
 - requiring delegation in the community required from many different individual physicians (as each patient may have a different physician)
 - deconstructing when physicians move away from the institution, leaving the physiotherapist unable to provide their services without authorization and delaying access to care
- Added time and costs related to daily service delivery
 - delays in communication of a diagnosis and thereby consent to treatment
 - unnecessary duplication of involving other providers in services that physiotherapists are already trained and competent to do
- Inconsistency in variation of medical directives and processes across different institutions and the province, with some members of the profession unable to do what others may do elsewhere due to understanding and exposure not skill
- Lack of flexibility for the health workforce when portability of providers is dependent on

organization of specific authority mechanisms (of authority gained through specific directives) to areas of need across the system.

Such limitations are contrary to professional and systemic aims regarding accessible, responsive patient-centred interprofessional care, and Ministry of Health and Long Term Care strategies for health human resources^{6,7,8} chronic disease management, diabetes aging at home and others^{9,10}. The limits appear to be unnecessary and likely unintentional, given existing competencies as well as experiences of other jurisdictions (as discussed more fully in Questions 32 and 33).

Two practice examples illustrate the limitations faced by members of the profession in Ontario:

Communicating a Diagnosis

In Ontario, unlike any other Canadian jurisdictions, under the current legislation, physiotherapists are not allowed to communicate a diagnosis. This is despite a physiotherapy diagnosis being included as a core competency of the curriculum of Ontario universities conferring academic degrees in physiotherapy and the National Physiotherapy Examination that is required for entry to practice independent practice in Ontario. Such competence is essential to timely response to immediate population needs and related imperatives, such as access to funding to cover the required services.

Communication of the physiotherapy diagnosis is critical to treatment planning and its communication is considered requisite for fully informed consent to treatment. Consent is made more complicated when other providers must be involved in the process, and the patient engaged in discussion about results of assessments and care planning. This is particularly critical when the physiotherapist is the primary access care provider for the patient. When attending for assessment and treatment, the patient reasonably expects to have the problem identified and to be informed of the physiotherapy diagnosis and the treatment plan, when consenting to treatment. Similarly, a physiotherapy diagnosis must be made and communicated in order to refer a patient for specialty or other provider care.

Administration of Oxygen:

Similar contradictions exist in that prior to the RHPA, physiotherapists administered oxygen to maintain oxygen saturation during interventions such as suctioning, treatments related to the mobilization of secretions, exercise, training and endurance assessment and training. With the absence of direct access by physiotherapists to this controlled act, the institutions in which they work have had to engage in lengthy processes to develop medical directives to allow physiotherapists to perform an act that they are already prepared to do (via their education and national examination). In the absence of these directives, other staff authorized to perform this act must also be engaged to participate in physiotherapy educational review and competency evaluation sessions, to ensure that patients receive the care they need. Such unnecessary duplication of service providers and the expanded administrative burden on institutions and providers (to maintain medical directives), perpetuate the underutilization of

6 Ontario MOHLTC 2005, *Laying the Foundation for Change*

7 HealthForce Ontario 2008, *Interprofessional Care*

8 HPRAC 2006

9 Ontario MOHLTC 2007, *Aging at Home Strategy*

10 Ontario MOHLTC 2007

competent health professionals, reduced responsiveness and system inefficiency.

Section 5 - Collaboration

[Question 14]

- 14. Do members of your profession practice in a collaborative or team environment where a change in scope of practice and the recognition of existing or new competencies will contribute to multi-disciplinary health care delivery? Please describe any consultation process that has occurred with other professions.**

Core competencies related to interprofessional teams, collaboration, communication and practice are part of the *Essential Competency Profile for Physiotherapists in Canada*¹¹ and are an integral part of the education system. Physiotherapists operate on an interprofessional basis from the outset, in their training and educational placements, and interprofessional skills and collaborative team management are part of core teaching from entry to practice. As part of their daily practice, physiotherapists work in collaborative and team practice environments in institutional and primary health care settings, and consult with a range of other professions across the continuum of care.

Implementing the proposed changes to scope of practice, controlled acts and other statutory provisions will improve interprofessional care overall, facilitating the kind of clarity of current and evolving roles, scope and accountability of physiotherapists¹². This will position physiotherapists to work to an optimal level of individual competence, and to demonstrate to professional colleagues a more up to date range of interprofessional contributions to serving the public. In return, as part of essential competencies (as presented in Dimension 2 of the *Essential Competency Profile*), physiotherapists are committed to understanding and respecting the competencies, expertise and perspectives of the professional colleagues they work with.

As pointed out in *Interprofessional Care: A Blueprint for Action in Ontario*,¹³ it is only when health professionals are able to work to the full extent of their competence within scopes of practice that they can maximize their contribution to more effective collaborative and complementary working relationships with professional colleagues. With a scope of practice that is truly reflective of current realities in physiotherapy practice today, there is significant potential to strengthen and improve interprofessional care across the system where physiotherapists currently work.

The enhancement of interprofessional care by expanded physiotherapist competencies has been demonstrated in the highly successful approach of physiotherapists in advanced practice roles with advanced competencies working in interdisciplinary hospital settings. As an example, their triage of orthopaedic patients has impacted positively on orthopaedic surgeon colleagues (who have more time to focus on surgery) and has improved access for patients to appropriate providers and treatment. Both results have implications for more timely and improved services, with attendant cost savings for the system (please see other illustrations of systemic cost/benefits in Questions 17 and 34). Benefits of recognition of physiotherapist competencies are also found in primary health care, defined in particular by commitment to interprofessional care. Physiotherapists are working in primary health care service delivery models to enrich teams and the menu of services available to patients. The potential is shown in the results of a Kingston initiative, which added physiotherapists and nurses to a Family Health Team to reduce the number of falls among seniors. The collaborative practice of

11 Accreditation Council for Canadian Physiotherapy Academic Programs, Canadian Alliance of Physiotherapy Regulators, Canadian Physiotherapy Association and Canadian Universities Physical Therapy Academic Council 2004

12 Health Professions Regulatory Advisory Council (HPRAC) 2008

13 Interprofessional Care Steering Committee 2007

physiotherapist and nurse produced a 26% reduction in the number of falls (and accordingly, reduced need for other providers). Another study concluded that physiotherapists treating musculoskeletal soft tissue injuries can fulfil many primary health care roles, including consultation in primary health care offices and providing early intervention clinics¹⁴ – all of which roles help to reconfigure utilization to address other areas of need.

The specific consultative input of other professions is discussed at Question 19.

Section 6 - Public Interest

[Questions 15-19]

15. Describe how the proposed changes to the scope of practice of the profession are in the public interest. Please consider and describe the influence of any of the following factors:

Critical strategic areas of focus of Ontario's Transformation Initiative include plans to improve access, shorten wait times, promote wellness and prevent illness, and to modernize the health infrastructure for the population of Ontario (Minister of Finance, Ontario Budget 2008). As health professionals located throughout the health system, in primary health care and other sectors, physiotherapists, practicing to the full extent of their competencies within the scope, are well positioned to achieve the goals for population health and the health system.

The changes proposed, including adjustment of the current physiotherapy scope statement, put particular focus on affording physiotherapists the authority to communicate diagnoses. Physiotherapists are already prepared (educated and tested) in this key area to support the expansion of scope, but currently cannot use that full set of competencies. Removing barriers to this function enables the profession to more immediately respond to a wide range of public needs associated with physical dysfunction, injury or pain and promote mobility and health. The authority for additional acts as identified earlier in the submission builds on the foundation of the diagnosis function to enable expanded breadth of capacity to serve the public interest as related to health and system performance.

The points below illustrate the many ways that physiotherapists are key health care providers that can contribute to the health needs of the population of Ontario in each of the targeted areas for health care improvement.

Improved access to services and growing population needs

Ontario's aging population and the increased prevalence of chronic diseases will expand the needs for health care related to mobility and cardiorespiratory impairments. As well, clinical areas such as acute and chronic musculoskeletal impairments, children with complex needs, workplace injury, and chronic disease management all add to the growing demand for community-based services. Physiotherapists are key team members for these populations and provide needed care to maintain and promote mobility, function and independence. The proposed additional controlled acts (such as administration of oxygen to maintain a patient's oxygen saturation level) will expand physiotherapists' capacity to more immediately and effectively deliver care as a primary contact, to serve diverse needs in the community.

¹⁴ Fenety, Anne and Tanya Nichol 2007

Shortening Wait Times

Effective utilization of resource personnel, including physiotherapists with additional authority to perform within their scopes of practice as proposed, can assert more impact on wait times, preventing bottlenecks in the public's access to appropriate care. Examples include various settings:

In the emergency room – A high prevalence of visits occur due to musculoskeletal conditions, trauma, and elderly seniors who have fallen. The public is often faced with long wait times and the numbers visiting the emergency, placing a high demand on staff. Currently there is a government strategy to reduce patient wait times. A physiotherapist is well prepared to participate in the emergency care team to assess such musculoskeletal conditions presented in the emergency room, and to communicate a diagnosis of a disease or disorder, that causes pain or movement dysfunction in order to provide or refer to appropriate care management.

For arthritic conditions waiting for an assessment by a specialist – This area has been specifically singled out by the government to reduce the wait times. Physiotherapists, when able to communicate a diagnosis of a disease or condition that causes pain or movement dysfunction, and with enhanced authorities to diagnose and treat the condition, can triage patients into the appropriate level of care. This method of triaging and system navigation for appropriate patients from wait list to an appropriate medical, physiotherapy, pharmacy, nutrition or occupational therapy care plan as examples can reduce the overall demand on the surgeon and increase access to the surgeon for those who need it. Some institutions have already tested this method of triaging with effective and cost efficient results.

Children with complex needs – Physiotherapists in advanced roles work with children with developmental delays, neuromuscular/spinal cord conditions and pediatric rheumatology. In these roles physiotherapists work collaboratively to increase access to care and minimize wait times and often provide outreach to underserved areas.

Wellness Promotion and Illness Prevention

Key areas of focus in primary health care and health system reform will benefit from the proposed changes to physiotherapy:

Women's Health - Current practice in pelvic floor re-education therapy supports muscle re-education as an effective approach to incontinence management. Incontinence has a major impact on the quality of life and health for many individuals. Getting appropriate care to such individuals has been limited by the stigma and social embarrassment caused by incontinence.

To make a difference, there is considerable potential for physiotherapists to provide more accessible management for these related conditions¹⁵. Their educational foundation includes both the anatomy and function of the pelvic floor and muscle re-education is core to the whole physiotherapy program. With the proposed additional controlled act enabling physiotherapists to use an instrument, hand or finger to address the labia majora or anal verge, the profession will be more accessible to provide the care in settings more appropriate to individuals' needs.

Chronic Disease Prevention and Management - Individuals with conditions such as obesity,

15 Neumann P. B., Grimmer K. A., Grant R. E. and V. A. Gill 2005

diabetes, arthritis, multiple sclerosis, chronic pain, and stroke will be increasingly prevalent, with dramatic trends projected for the aging Ontario population. Movement dysfunction, mobility issues, ulcers, and pain are disorders commonly associated with these diseases. The physiotherapy profession is well prepared through their education and training to provide management for these conditions, as part of an interprofessional team. The addition of the controlled acts, such as procedures below the dermis, would strengthen and broaden physiotherapists' capacity to contribute positive timely health outcomes.

Falls Prevention Programs - In the community and in long term care, physiotherapist falls prevention programs help prevent injury and acute hospitalization. When expanded to include ordering x-rays in cases when osteoporosis is suspected, timelines for determining the treatment pathway and appropriate referral would be reduced.

Modernizing the Health Infrastructure

Steps taken to reinforce the capacity and utilization of health personnel are integral to aligning appropriate health system resources with current and future needs. Examples where the proposed changes for physiotherapists could make a difference include:

Resource Requirements - Health human resources have been challenged to keep up with the demand for physicians and nurses in all sectors of health care. Physiotherapists have the competencies to provide care in high demand areas of health care such as orthopaedics and chronic disease management.

As well, community based healthcare delivery requires greater overlap of scopes of practice of various practitioners as there are a limited number of professionals who can realistically visit patients in these community sites. It is more efficient and cost effective to have those community based practitioners delivering care to the full extent of not only their practice, but also their education and their competencies.

Physiotherapy Professional Service Opportunities - A greater number of physiotherapists registered with the College are community based (60%). A scope of practice that reflects their training and learning facilitates delivery of care in the community where alternate authorization are more difficult to obtain. Physiotherapists who are able to perform to the full breadth of their competence within the professions' scope and education (entry to practice and post graduate) demonstrate improved professional satisfaction, thereby reducing attrition. The proposed scope of practice for physiotherapy will promote the greater application of physiotherapy education and experience to allow greater access to appropriate care for the population.

In summary, with the proposed changes, physiotherapists as primary contact practitioners in many areas of practice (and predominantly in community-based settings) will be able to contribute significantly to the interprofessional health care team. The revised scope and authorized acts will enable physiotherapists to perform a greater role in care management and system navigation needed to improve both health and health system performance.

16. How would this proposed change in scope of practice affect the public's access to health professions of choice?

A scope of practice that more accurately reflects physiotherapists' competencies would allow patients to choose to be treated by physiotherapists in more components of the continuum of care in more delivery venues. Patient convenience would be markedly improved by reducing the need for referrals to other health professionals in order to obtain a diagnosis or to order x-rays or other diagnostic tests in circumstances related to physiotherapy scope of practice.

Removing the current barriers implicit in scope and the controlled acts afforded to physiotherapists will enable the public to more immediately benefit from the array of services that physiotherapists provide. With an enhanced scope of practice for physiotherapists and their capacity expanded to readily address needed services, the public will have more timely access to services they did not have before.

In summary, the proposed scope of practice reflective of physiotherapists' competencies will lead to positive impacts on services across the continuum of care.

17. How would this proposed change in scope of practice affect current members of the profession? Of other health professions? Of the public? Describe the effect the proposed change in scope of practice might have on:

The proposed change in scope will provide positive effects for the profession, other health professions and the public, in the many areas identified below.

a. Practitioner availability

The proposed changes would improve availability of practitioners across the system, given the range of roles and settings in which physiotherapists now serve. All physiotherapists have the ability and competence to work across the health continuum (primary health care, acute care, long term care and community). Already, those members of the profession who are working in advanced practice roles (through medical directive/delegation models), have already demonstrated how the profession can offer more immediate and expansive response to population needs, in both primary and specialty care.

Many physiotherapists have indicated an interest in participating in roles that allow them to maximize their skills. The proposed approach will provide greater flexibility for physiotherapists to develop and optimize their competence in one or more of the additional authorized acts as related to population health and health system needs locally.

Additionally, the public could be advantaged by the replication of models such as orthopaedic triage provided by physiotherapists in a number of Ontario hospitals that has resulted in more availability of orthopaedic surgeons. Physiotherapists developing demonstrable competence in one or more of the additional authorized acts should create a greater availability of physiotherapists to offer other services needed by the public such as incontinence assessment and therapy, wound care and more.

A number of studies have demonstrated that when physiotherapists are providing services extended beyond the entry to practice competency, they deliver appropriate levels of care and enable medical staff to be deployed in more appropriate areas¹⁶.

Physiotherapists are required to be competent in interdisciplinary collaboration with other

¹⁶ Weatherly C.R. and P.G. Hourigan, 1998 & Durrall, S. 1996

professionals. Physiotherapists working to the maximum of their competencies and scope in institutional settings, community and primary health care will allow for 'sharing the work load' and 'task-shifting' which would result in a positive adjustment to the availability of all providers including physicians.

b. Education and training programs, including continuing education

Physiotherapists receive a theoretical basis for assessment, diagnosis, treatment and practical skills that position them well to perform a number of the additional authorized acts or where necessary, to pursue additional training/education for the proposed additional authorized acts.

Additional post-graduate training/education to develop the appropriate level of competency for these authorized acts is available. Examples include University of Toronto (e.g. wound care), University of Western Ontario (e.g. wound care/ Master of Clinical Sciences in Manipulation), Quebec program to assess/treat incontinence, McMaster University (Rehabilitation Science Masters Program - training in ordering x-ray, MRI and diagnostic ultra-sound), Advanced Clinician Practitioner in Arthritis Care - St. Michael's Hospital and Sick Children's Hospital (ACPAC program - training in ordering x-ray, MRI and diagnostic ultra-sound).

Established continuing professional development programs support ongoing education needs related to physiotherapy competencies in all areas proposed. This includes programs related to the authorized acts (e.g. incontinence training, understanding use of medications in arthritis care, cardio-respiratory upgrading courses, understanding uses for/roles in diagnostic tests and x-rays).

c. Enhancement of quality of services

Physiotherapists with additional competence in one or more of the authorized acts requested are already providing care in Ontario settings working under medical directives / delegation. A number of similar activities have been documented in other jurisdictions that provide insights as to the potential for improvements in quality.

A recent study in Kingston Ontario showed that a "physiotherapist and an orthopaedic surgeon made similar diagnoses and have similar levels of accuracy in making a clinical diagnosis for non-complex musculoskeletal impairments of the knee and shoulder". Further, the study demonstrated that "the treatment recommendations made by the surgeon and the physiotherapist were highly similar for primary recommendations, however the physiotherapist tended to make recommendation in almost every case for education and exercise, which are the hallmarks of conservative management in musculoskeletal impairments"¹⁷ .

A US study comparing diagnosis accuracy between physical therapists, orthopaedic surgeons and non-orthopaedic providers demonstrated that the physiotherapists and orthopaedic surgeons were in agreement and both were more accurate than the other providers¹⁸ .

In another study, 53% of the recommendation for knee arthroscopy made by physiotherapists with advanced competence were confirmed by arthroscopic findings compared to only 37% of physicians and surgeons¹⁹ . Other studies have concluded that physiotherapists with advanced competencies

¹⁷ Aiken, Alice and Mary Ann McColl, 2008

¹⁸ Moore, J.H. and D.L. Goss 2005

¹⁹ Gardiner, J. A and Phillip Turner 2002

managed orthopaedic patients as well as sub-consultants^{20,21}. In addition, these studies demonstrate that patients who don't need surgery are appropriately referred to physiotherapy treatment while others who need it access surgery.

Primary care physiotherapists responding to musculoskeletal soft tissue injuries demonstrated effective functional outcomes²². A UK case study of an adolescent pain management program with an interdisciplinary team with daily physiotherapy sessions resulted in less distress, disability and anxiety after three months of treatment and less stress for parents.

d. Costs to patients or clients

When patients are unable to access the right provider, in a timely fashion for the right services, they may bear personal costs due to complications (e.g. lost time from work, cost of support, medial support until appropriate care/treatment is ready) and the system may bear additional cost due to health complications due to delays. The proposed changes for the scope of practice for physiotherapists will contribute to improving access to physiotherapists for injuries or illness and to physiotherapists with additional expertise and authorization for additional acts to serve the public need. The potential for enhancement of appropriate access in hospital, community and primary health care settings will also include physiotherapists redirecting patients as required to other appropriate providers. Improved care management and system navigation will assist in reducing associated costs to patients.

As one example, an Ontario study demonstrated the significant economic burden of disabling osteoarthritis (OA) from the perspective of individuals living with this condition. Costs were mainly for time lost from employment and leisure, and for unpaid informal caregivers.

e. Access to services

The proposed scope of practice for physiotherapy in Ontario includes both diagnosis, and a commitment to wellness and health promotion. This foundation plus greater flexibility to prepare to assume additional authorized acts in response to population health needs should mean greater recognition of the benefits of the physiotherapist roles in hospitals (e.g. triage, other interprofessional collaboration), community (long term care/elderly) and in primary health care teams.

The changes in scope will provide greater direct access to health services that can be provided by physiotherapists in the areas of physical function. This will become increasingly important as the population ages and prevalence of chronic diseases increase.

There also exists increased potential for the utilization of physiotherapists in home care settings, for example to titrate oxygen or provide wound care, in situations where the physiotherapist is already a care provider in the home. This would allow for better use of nursing and other professions resources to be redirected to see other patients needing their services. Additional benefits achieved would include improvement of timely access to needed care, minimizing complications for the patient in the home, reducing the needs for admission to hospital. These would all support current health system initiatives towards ageing at home.

20 Daker-White et al 1999

21 Hattam, P. 2004

22 Fenety, Anne and Tanya Nichol 2007

The capacity to order diagnostic tests would reduce unnecessary delays for patients. Access to additional diagnostic procedures facilitate interprofessional collaboration by ensuring that needed information is included in discussions with physicians and other providers and that patients are assisted to the appropriate level of care.

Current physiotherapy triage in Ontario hospital based orthopaedic clinics has resulted in improved access for patients to the most appropriate services in terms of physiotherapy treatment where surgery was not indicated and to an orthopaedic surgeon when it was. In turn, orthopaedic surgeons benefited from the triage work of physiotherapists that freed them up so that they could spend more time operating. The Alberta Bone and Joint Institute clinics where physiotherapists were part of an interprofessional team contributed to achieving a reduction in wait of 29 days (35 weeks down to 6) in wait times for the initial review with an orthopaedic surgeon²³. A study of similar activity in the UK found that 80% of clinics employing physiotherapists reported a reduction in waiting times for patients with back pain²⁴. Another study resulted in a reduction of waiting time for orthopaedic clinics²⁵.

While such strategies have reduced waiting times in Ontario it is important to indicate that this new approach needs to be maintained and replicated to ensure further reductions in wait times for hip and knee replacements.

f. **Service efficiency**

With physiotherapists' improved access to the authorized acts for which they are competent, less time will be spent on creating medical directives or providing direct orders. In addition, directives are specific and therefore restrictive. Such directives are not transferable to another institution, which limits access, portability and flexibility of health human resources.

A study in Kingston demonstrated that a "physiotherapist is the appropriate non-physician healthcare provider to screen patients referred to orthopaedics for total hip replacement and total knee replacement surgery" given that they have the "knowledge to make the same determinations as the surgeon with regard to need for surgery, and there is value added for the patients in terms of the increased likelihood of referral to conservative management whether they require surgery or not". As a result there is an "increase to the time the surgeons have available to spend in the operating room by decreasing the amount of time they have to spend in clinics seeing patients who do not require surgery"²⁶.

Overlaps in scopes of practice allow better use of scarce resources. This would have particular relevance in rural areas with shortages of all providers, and in home based care. Physiotherapists given authority to perform a greater number of controlled acts autonomously; ordering tests, administer oxygen, and assisting with wound care, would contribute to the freeing up the nurse or physician from making a home visit, which also saves the expense associated with travel.

There is potential to reduce the time patients spend in emergency departments when a physiotherapist is used to triage orthopaedic cases, and could order tests that would be available for the physician as soon as the doctor was able to see the patient.

23 The Alberta Bone and Joint Institute 2005

24 Weatherly and Hourigan 1998

25 Hattam, P and A. Smeatham 1999

26 Aiken, Alice B., Mark M. Harrison, Marg Atkinson and John Hope 2008

In a UK study, the introduction a physiotherapist with additional competencies to an acute knee screening services was found to “improve the quality of care of acute knee injuries, save medical time and foster cooperation across the services with NHS (rest of the health system)”²⁷.

g. Interprofessional care delivery

Essential competencies for physiotherapists include communication and collaboration. The expectation is working with other colleagues to plan, coordinate, and evaluate patient services; sharing information with other professions and showing respect for the expertise and perspectives of other providers. The new scope and the flexibility achieved with additional authorized acts positions physiotherapists to better support the replication of already successful Ontario based practices, such as triage and other work in hospital settings, and to provide more services at the community and primary health care front to enrich the professional teams service profile and better meet the needs of the public served.

There will be greater clarity of the scope and the roles for the physiotherapists with the requested changes to reflect current practice. This will further facilitate collaboration and interprofessional care. Further discussion of interprofessional collaboration can be found in the response to question 14.

h. Economic issues

For the public, the economic burden of being unable to work while awaiting treatment is reduced when the health system and needed care can be more efficiently accessed.

Systemically, with the reduced dependency on medical directives, there should be less administrative and clinical costs related to the creation of medical directives and delegations. Specific to each institution, they must be reviewed and recreated when health professionals change. They have no portability and must be recreated when the professional moves to a new institution.

With a scope of practice more in keeping with national and international norms, physiotherapists will be better able to achieve professional goals, greater mobility in the system and be more responsive to the needs of health teams and patients. In turn, this would improve recruitment and retention in Ontario at a time when there are shortages in health professionals, including physiotherapists.

A number of studies have demonstrated potential savings for the system and for patients. This includes the potential for reduced economic impact on the public with more timely access to appropriate care as illustrated in examples above. For example, one study showed that primary care physiotherapists responding in a timely fashion to musculoskeletal soft tissue injuries were shown to significantly reduce time loss-from-work²⁸. A randomized trial demonstrated that the use of specially trained physiotherapists working in an extended role were as effective as post fellowship junior staff and clinical assistant orthopaedic surgeons in the initial assessment and management of new referrals to outpatient orthopaedic departments and generate lower initial direct hospital costs²⁹.

Using physiotherapy for health promotion reduces lost time at work by increasing access to management of their physical dysfunction, and reducing work place injury has economic benefit to both industry and the patient. Prevention strategies may assist in preventing development of chronic disease, having large cost saving for all levels of the health care system as well as employers and

27 Jibuike, O.O. et al 2003

28 Fenety, Anne and Tanya Nichol 2007

29 Daker-White et al 1999

employees. Services to the elderly in the community can reduce hospitalization when able to provide wound care, oxygen administration, incontinence training, and programs to prevent falls. One study illustrates that strength and endurance training with pulmonary rehabilitation improved shortness of breath, quality of life and reduced the number and length of hospitalizations³⁰.

i. Other impacts

Health human resource shortages facing the system also affect physiotherapists so strengthening the attraction and career opportunities and pathways for physiotherapists can improve and reinforce recruitment and retention. Allowing physiotherapists, now entering practice with a Masters degree, to utilize their skills and competencies and to have the opportunity to further advance and utilize these skills will likely help to retain physiotherapists within their profession and within the province. They may be less likely to be attracted to move their practice to other jurisdictions that allow physiotherapists to maximize their competence directly (i.e., Alberta, USA).

There would also be less incentive to leave the profession to pursue other careers, when physiotherapists are able to utilize their expertise providing direct patient care, especially for clinicians who have developed expertise in a particular area of practice.

18. Are members of your profession in favour of this change in scope of practice? Please describe any consultation process and the response achieved.

The short time line to respond to HPRAC's request has been a challenge in consulting fully with the profession and others who may have an interest in or be affected by the proposed changes. As such, the consultation phase cannot be considered comprehensive. Nevertheless, considerable effort has been made during the preparation of this submission to connect with informants in Ontario, across Canada and in other countries.

It is important to note that this conversation is not, however, new to the profession and in particular over the last two years has had heightened awareness and input.

For example, in a survey of physiotherapy members through the OPA regarding communicating a diagnosis, 96.8% supported the position of the Association that this is part of their scope of practice and the not having this authorized act impacts on patients, the health system, and the ability of physiotherapists to work to the maximum of their competencies and scope.

A webcast held on June 18, 2008 for the profession regarding this submission was followed by an email survey to assist with measuring current profession support with the direction proposed. Over 250 sites (averaging approximately 1200 of 6700 physiotherapists in the province) attended the session. Over 275 responses were received – a significant ratio based on polling experience and analysis. Of those that responded to the questions posed, the results reflect the following.

- 95% are in support of the scope statement
- 90% are in support of all the controlled acts proposed
- at least 95% support the authority to order x-rays and refer to specialists
- approximately 85% are in support of ordering lab tests
- over 97% believe the changes will facilitate better collaborative patient care
- 94% are confident that the combination of the responsibility for self regulation and the

³⁰ Ries, A.K et al 1997

College standards will ensure appropriate practice

19. Describe any consultative process with other professions that might be impacted by these proposed changes.

The consultations held to date have not identified substantial opposition to the proposal. Instead, thoughtful input has been provided by other professions as to the importance of assuring the changes actively promote collaborative care models and do not undermine the substantial progress the government has made in this area. As noted above the short time line to respond to HPRAC's April request has not allowed sufficient time for comprehensive consultation with all professions and others who may have an interest in or be affected by the proposed changes. As such, this aspect of the consultation phase cannot be considered comprehensive or fully conclusive. Professions consulted in either or both the regulatory and association collegial relationship include medicine (including orthopaedic specialists), nursing, nurse practitioners, medical radiation technology, pharmacy, and medical laboratory technology.

Section 7 - Risk of Harm [Questions 20-25]

20. How will the risk of harm to the patient or client be affected by the proposed change in scope of practice?

When accessing the authorized acts, the profession does not anticipate a material change to the risk of harm for patients as a consequence of the proposed changes to scope of practice and authorized acts. Physiotherapists are fully trained to perform the authorized acts safely and effectively and to identify contraindications to their performance. The aim of the proposed change is to clarify the scope statement, to better enable physiotherapists to practice to the full extent of their competencies and capture their current range of practice activities, including diagnosis.

The scope statements of many professions already have a significant degree of overlap, for example, those of physiotherapy, nursing, occupational therapy, etc. (please see further discussion of this in Question 21). And physiotherapists may not perform a controlled act or treat someone where it is reasonably foreseeable that there may be harm to the patient (per Section 30 of the RHPA - treatment where risk of harm).

It is also important to note the proposed authorized acts are already part of physiotherapy practice in a number of other jurisdictions in Canada and in the United Kingdom. In all Canadian jurisdictions, physiotherapists must assess their competence, be in compliance with standards of practice and where necessary for restricted or authorized acts, demonstrate to the colleges that they have the education, and the competence when working in special areas.

For example, in Alberta, the approach is to authorize some restricted activities for entry to practice physiotherapists (e.g. wound care/debridement) while other restricted activities are addressed through requiring licensed physiotherapists to provide evidence of advanced training approved by the Council and then being placed on a specific roster. Physiotherapists in the United Kingdom are authorized to perform all the authorized acts being requested here. Like Alberta, a number of acts are considered to have preparation at entry to practice such as administering oxygen, while others are an extended level of work and requires supportive evidence to their college of appropriate education, experience, and competence.

However, where there may arise any potential to expose patients to risk of harm, the profession will recognize this risk and will mitigate it in a number of ways:

- The College has established a Standard for Professional Practice: Performing Controlled Acts that clearly describes the professional expectations on registrants relating to perform controlled acts. This standard only permits registrants to perform controlled acts when, assessments are done, risks are assessed and discussed with the patient, competence is assured and professional responsibility is taken. This could easily be shaped as a regulation.
- This obligation is reinforced with a professional misconduct regulation that requires registrants to uphold the standard of practice of the profession and practice within individual sphere of competence.
- The College also has a robust quality assurance program in place that requires registrants to periodically submit to practice reviews by their peers in which the kinds of practice activities they perform are assessed for potential to cause harm to patients.

The approach taken by Colleges in other jurisdictions and in Ontario is to apply additional measures of oversight where any activity warrants it for public safety

Physiotherapists in Ontario are also required to carry malpractice insurance. Current insurance parameters satisfy the addition of the proposed controlled acts as well as the need of other providers and their respective malpractice models in the spirit of shared care.

21. What other regulated and unregulated professions are currently providing care with the competencies proposed as an expansion to your scope of practice? By what means are they performing it? (under delegation, supervision or on their own initiative?)

Scope of practice statements have considerable overlap and are not exclusive to one profession. The flexibility inherent in the scope of practice model in the RHPA allows a wide variety of regulated and unregulated professions to provide care that may be in some fashion based on the same competencies that underpin both the current and proposed revisions to the scope of practice of physiotherapy. As such, scope statements do not prevent people from providing health care that is within the scope of practice of a profession, and in this context delegation and supervision are not required.

To illustrate, the following points summarize the variety of other professions providing care that is related to the expansion of scope and additional authorized acts proposed in this submission for physiotherapists.

Proposed Additional Controlled Acts for all Physiotherapists

- **Communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person's symptoms**

Physicians, podiatrists, chiropractors, dentists, optometrists and practitioners of Traditional Chinese Medicine are authorized to "communicate diagnoses." Their authority is limited to diagnoses relevant to the provider's scope practice as designated in regulations. The extended class of nurses can also communicate a diagnosis identified through methods involving: the patient's health history, the findings of a comprehensive health examination, or the results of any laboratory tests or other tests and investigations that the member is authorized to order or perform. As well, naturopaths currently do so by virtue of an exemption under the s.s. 26(3) of the RHPA, but will be authorized to do so

directly when the *Naturopathy Act, 2006* is proclaimed.

- **Treating a wound including by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.**

Physicians, podiatrists, and chiropractors are authorized to perform this activity below the dermis, which would be similar in procedure to those described immediately prior. Dentists may do so with respect to the oral facial complex including teeth and dental hygienists may do so with respect to teeth and surrounding tissues.

- **Administering, by inhalation:**
 - i. **oxygen, or**
 - ii. **a drug or substance that has been ordered by person who is authorized to do so by the *Chiropractic Act 1991*, the *Dentistry Act, 1991*, the *Medicine Act, 1991* the *Nursing Act, 1991* or the *Midwifery Act, 1991*.**

Physicians, dentists, medical radiation technologists, midwives, naturopaths, and nurse practitioners are all authorized to administer substances through inhalation. Nurses that are not in the extended class and respiratory therapists are authorized to administer substances through inhalation when ordered by a member of a health profession authorized to do so.

- **Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment or treatment**

Physicians, midwives, and extended class nurses are authorized to perform this controlled act. Nurses that are not in extended class can perform this act if ordered by a professional authorized to do so. As well, naturopaths currently do so by virtue of an exemption under the s.s. 26(3) of the RHPA, but will be authorized to do so directly when the *Naturopathy Act, 2006* is proclaimed.

- **Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder,**
 - i. **the application of electromagnetism for magnetic resonance imaging, and**
 - ii. **the application of sound waves for diagnostic ultrasound.**

Physicians, dentists extended class nurses and optometrists are all authorized to perform elements of the controlled act of applying or ordering the application of a prescribed form of energy. Physicians and dentists are authorized to apply or order the application of forms of energy; extended class nurses are authorized only to order the application; and optometrists are authorized only to apply forms of energy.

22. Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health professional, both currently and in the context of the proposed change in scope of practice.

Physiotherapists operate under a current obligation to make referral when it is appropriate to do so, which would also apply in the context of the proposed change in scope of practice. In general, a referral should occur whenever the physiotherapist recognizes or ought to recognize an abnormality or conditions that would be more appropriately or better served by another health professional

More specifically, this responsibility is set out in multiple areas of *The Essential Competency Profile for Physiotherapists in Canada* (July 2004):

- **Dimension Five:** (physiotherapy diagnosis/clinical impression and intervention planning), Element 3: (Facilitates informed decision-making by clients) Performance Criteria (e): states that the physiotherapist must “Explain the situation to the client who is being referred to elsewhere for intervention”. The explanation may include the reason for the referral, anticipated costs, information that will be shared with the practitioner, and any interest or involvement in the referral; and
- **Dimension Six:** (Implementation and Evaluation of Physiotherapy Intervention), Element 3 (Plans for timely completion of physiotherapy intervention and follow-up, as required, to meet the client’s needs), Performance criteria (d) identifies and recommends options for ongoing or follow up service for the client a number of options including “refers to other services if indicated”

In addition, physiotherapy education³¹ incorporates this responsibility within such areas as protocols related to diagnosis: If the evaluation reveals findings that do not fall within the scope of therapy practice, the therapist refers the client to other health professionals who are able to intervene appropriately [including to] give reasons for the referral to another health care professional.

The responsibilities are ultimately reinforced by the College’s professional misconduct regulation (861/93 under the *Physiotherapy Act*), that includes a general obligation for registrants to refer a patient to another health professional in circumstances when they recognise or ought to recognise an abnormality or condition which indicates such a referral.

Such statements illustrate the essential message. These rules will be used in the future in relationship to the proposed scope of practice and the additional authorized acts, just as they currently apply to the existing authorized acts. This reinforces the expression of protection of public safety in professional standards.

23. If this proposal is in relation to a current supervisory relationship with another regulated health profession, please explain why this relationship is no longer in the public interest. Please describe the profession’s need for independence/autonomy in practice.

Within the larger scheme of interprofessional collaborative care, the physiotherapist has operated for some time as an autonomous, accountable primary contact professional. Patients may access physiotherapists directly without a referral from a physician or other professional. As members of collaborative teams of health professionals, physiotherapists’ relationship with other professions is not one that is supervisory; rather it is complementary in nature – each bringing strengths to serve common goals for needed care.

The proposed changes to scope and authorized acts will align the profession more completely with the current and evolving practice of physiotherapy across Canada and internationally. Such change is more in keeping with international trends toward task shifting³², depicted by the World Health Organization’s Global Recommendations and Guidelines for Taskshifting as: “the rational redistribution of tasks among health workforce teams.” The report explains further that “task shifting can make more

³¹ University of Ottawa Faculty of Health Sciences 2008

³² World Confederation for Physical Therapy 2008

efficient use of existing human resources and ease bottlenecks in service delivery.” The aim overall is to overcome issues involved in traditional relationships, to free up and expand capacity across health systems.

Interprofessional relationships have in general promoted the development of the profession by enabling physiotherapists to engage in advanced practice activities through the use of delegation and directives. The proposed changes to scope of practice and authorized acts are intended to remove limitations associated with elements of delegation and directives where necessary (as discussed more fully in Question 13). Changing the authority mechanisms for acts supported by competency that meet College standards will not alter the act of collaboration necessary for quality patient care and system efficiencies.

To illustrate, physiotherapists who have already acquired additional competencies in the areas for proposed change are currently constrained, primarily in hospitals, under a medical directive/ delegation in order to function at a level for which they are already competent, and could more readily contribute to interdisciplinary initiatives. The current approach is cause for concern for a number of reasons, including delays of care and the variation in how the directives are expressed in many different settings across the province. This leads to a lack of mobility and flexibility of physiotherapists to other areas of the system in need (e.g. to benefit patients in another hospital on the merit of their proven expertise). Their expertise is particularly subject to loss of authority in work if the physician(s) leaves to go elsewhere, rendering the physiotherapist unable to act without delegation.

Such issues for practice have not served the public interest for access to responsive care. By contrast, the proposed changes will bring in standards, quality, and mobility of this expertise to benefit the public in many institutions (now freed of the cumbersome mechanisms required in-house to recognize them) and to other sectors where this will enhance and strengthen interprofessional teams and promote innovation in services that are truly responsive to the public.

24. Does the proposed change in scope of practice require the creation of a new controlled act or an extension of or change to an existing controlled act? Does it require delegation or authority to perform an existing controlled act or subset of an existing controlled act?

No change is required to be made to the current list of 13 controlled acts in the *Regulated Health Professions Act*. Nor is there a requirement for an extension of or a change to an existing controlled act.

25. If the proposed change in scope of practice involves an additional controlled act being authorized to the profession, specify the circumstances (if any) under which a member of the profession should be permitted to delegate that act. In addition, please describe any consultation process that has occurred with other regulatory bodies that have authority to perform and delegate this controlled act.

A physiotherapist is not permitted to delegate at this time. The College’s current professional misconduct rule contains an absolute prohibition on members of the physiotherapy profession delegating a controlled act they are authorized to perform. The current regulation defines “Delegating a controlled act” as professional misconduct (Regulation 861/93 under the *Physiotherapy Act*).

The College has proposed changes to some aspects of its professional misconduct regulation based on the profession’s desire that it be given the authority to practice to its full competence within scope as well as the trend toward more participating fully in interprofessional collaborative care. In this

context the College is proposing to amend the current absolute prohibition on delegating controlled act to a rule that is more reflective of the profession's competencies.

While the revised professional misconduct regulation has not received final approval from the Ontario government, the wording that the College has proposed and which the College understands is in the process of being approved is:

“Delegating a controlled act to another person unless that person has the knowledge, skills and judgement to perform the controlled act”.

When this change receives final government approval, physiotherapists will be able to delegate controlled acts but only in circumstances where the person who accepts the delegation has met the expectations in this regulation.

Please see Question 19 for information on the consultation process the College has used with respect to its general proposal including controlled acts.

Section 8 - Competencies / Educational Requirements for Practice

[Questions 26-30]

26. **Are the entry-to-practice (didactic and clinical) education and training requirements of the profession sufficient to support the proposed change in scope of practice? What methods are used to determine this sufficiency? What additional qualifications might be necessary?**

The entry to practice (didactic and clinical) education and training requirements of physiotherapists are entirely sufficient to support the proposed change in scope of practice. The curricula of all five entry to practice programs in Ontario, like the other nine in other Canadian provinces, are shaped by multiple documents and standards:

- the *Essential Competency Profile for Physiotherapists in Canada* [ref] published by the Canadian Physiotherapy Association;
- the Accreditation Standards for Physiotherapy Education Programs in Canada [ref] published by the Accreditation Council for Canadian Physiotherapy Academic Programs (ACCPAP);
- the Exam Blueprint for the national Physiotherapy Competency Examination published by the Canadian Alliance of Physiotherapy Regulators, which is itself guided by the Alliance's Analysis of Practice; and
- curriculum guidelines from the Canadian Universities Physiotherapy Academic Council (CUPAC).

Support for scope of practice statement and the act of communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person's symptoms

In the *Essential Competency Profile for Physiotherapists in Canada* (2004), Dimension Five of seven dimensions is entitled “Physiotherapy Diagnosis/Clinical Impression and Intervention Planning,” and its elements describe the features of how a physiotherapist “[a]nalyzes data collected, establishes the physiotherapy diagnosis/clinical impression and prognosis, and develops a client-centred physiotherapy intervention strategy.” One of the four elements is simply that an essential competency of a physiotherapist is that s/he “establishes a physiotherapy diagnosis/clinical impression.”

In the Accreditation Standards for Physiotherapy Education Programs in Canada (2004), Standard 6.3 is entitled “Physiotherapy Diagnosis and Intervention Planning” and its core description is that “Physiotherapy students, upon graduation, will demonstrate the ability to analyze a client’s needs, establish a physiotherapy diagnosis and prognosis, and develop a physiotherapy intervention strategy that is based on best evidence and is outcome-focused...” The ACCPAP reviews – regular periodic or triggered by substantive program change such as the transition from baccalaureate to master’s level – examine a program’s compliance with all standards through evaluating not only self-study reports and interviews but also examples of how concepts are taught and how students’ competencies are evaluated. Accreditation from ACCPAP is simply too important for any entry to practice program to lose; ACCPAP’s clear criteria in relation to physiotherapy diagnosis ensure that all physiotherapists are taught and tested appropriately in this competency.

CUPAC recently undertook a project to revise/update the 1995 document entitled Entry-Level Curriculum for Canadian Physical Therapy Programs: Guidelines for Faculty. The draft document entitled Entry-to-Practice Physiotherapy Curriculum: Content Guidelines for Canadian Academic Programs (2008) was approved in principle at CUPAC’s annual meeting in May 2008 and its final version will be available in a few months’ time. This document was the result of extensive consultation of academic physiotherapists across Canada. In the sections about curriculum content in the neuromuscular, musculoskeletal and cardiorespiratory systems – i.e., the systems listed in the newly proposed scope statement – the CUPAC document makes clear that developing students’ competencies at using clinical reasoning to develop a physiotherapy diagnosis is a normal part of all programs’ curricula.

In summary, all five entry to practice programs in Ontario are driven to maintain high standards in the teaching and evaluation of entry to practice physiotherapists’ ability to communicate a diagnosis. Moreover, because entry to practice in Ontario requires successful completion of the national Physiotherapy Competency Examination, which is itself reflective of Canadian education and practice standards, all those seeking to become registered physiotherapists in Ontario must meet the same standards as those who graduate from Ontario entry to practice programs.

Support for each of the other proposed controlled acts and changes to other statutory provisions

The other proposed controlled acts and changes to other statutory provisions are also supported by the entry to practice education requirements for physiotherapists. Most of these proposed acts and changes relate to particular areas of practice or categories of patient care. Evidence regarding the extent to which each of these proposed acts and changes is supported by entry to practice education is presented in Appendix A, B, C. This evidence was drawn by recent consultations with all Ontario programs as well as review of the documents described above.

For some proposed acts – e.g., the proposed component of a controlled act that includes the administration of oxygen to maintain a patient’s oxygen saturation – the evidence supports that this competency is taught to and evaluated in all physiotherapy students. For other proposed acts and changes, there is “partial” support in entry to practice education requirements, generally meaning that there is adequate core content for partial competency among all graduates. The development of full competency requires supervised experience in specific practice environments and/or post-graduate education. The fact that the current submission proposes that all physiotherapists be authorized under law to perform acts that not all are competent to perform at entry to practice should not be grounds for concern because of the College’s current and proposed processes for ensuring that

physiotherapists' competency is attained and maintained. See responses to questions #20 and #28. Entry to practice education will support those current and proposed processes, as described below.

Support for a regulatory model in which the scope and legal authorities are greater than are achieved by all at entry-to-practice

The same documents described above that shape entry to practice curricula about “communicating a diagnosis...” also very clearly shape entry to practice education to ensure that graduates understand the regulatory model in which they will work as physiotherapists. In the Essential Competency Profile for Physiotherapists in Canada (2004), the first element of Dimension One is that a physiotherapist “[c]onducts self within legal/ethical requirements.” One of the criteria within this element is “Provides services within profession’s scope of practice and personal competence.” In the Accreditation Standards for Physiotherapy Education Programs in Canada (2004), Standard 6.1 is entitled “Professional Accountability” and its core description includes that “Physiotherapy students, upon graduation, will... have knowledge of... the scope of physiotherapy practice, standards of practice,... regulatory requirements, laws and jurisprudence...” Descriptions of these curricular content areas in the draft Entry-to-Practice Physiotherapy Curriculum: Content Guidelines for Canadian Academic Programs (2008) mirror those in the other documents. Within Ontario, professional practice education includes the teaching and testing of how the College’s processes track the attainment and maintenance of competency at the two controlled acts currently authorized to physiotherapists.

Thus, current education in Ontario entry to practice programs, and indeed in graduates from outside Ontario, supports a model in which physiotherapists look to the provincial regulatory body for standards and guidelines in relation to competency and controlled acts.

27. Do members of the profession currently have the competencies to perform the proposed scope of practice? Does this extend to some or all members of the profession?

In keeping with the response to question 26, all members of the profession have the baseline knowledge of physiology and anatomy that enable them to perform the activities contemplated by the revised scope and authorized acts when the additional requirements of the profession are met.

Competence for some acts is attained in entry to practice education:

- Communicating a diagnosis
- Administering oxygen

Others acts require additional education to attain competence. Through continuing education, physiotherapists continue to build on this base education and develop the competencies specific to the controlled acts. In these cases only those physiotherapists with the competencies required by the College of Physiotherapists of Ontario standard on the performance of controlled acts could perform these acts.

- wound care
- incontinence
- ordering MRIs/diagnostic ultrasound
- administering other substances by inhalation
- ordering x-rays
- ordering lab tests

28. What effect will the proposed change in scope of practice have on members of your profession who are already in practice? How will they be made current with the changes, and how will their competency be assessed? What quality improvement/quality measurement programs should or will be put into place? What educational bridging programs will be necessary for current members to practice with the proposed scope?

There will be minimal impact on the profession as the changes requested reflect current practice. Education programming in entry to practice support these scope changes. There are well established continuing professional development programs to support the authorized acts which lead to specialization in wound care and incontinence assessment and treatment.

The strength of the model is that it will only permit those physiotherapists who have the required competencies to perform authorized acts. As is the current situation, no physiotherapist is required to perform these authorized acts and the capacity to perform them is based on standards of practice set out by the College.

The Association, the College and the chairs of the academic programs in Ontario meet regularly in the form of the Ontario Physiotherapy Leadership Consortium and joint strategies will be developed and implemented to ensure that all physiotherapists in Ontario are made aware of the changes, their accountability associated with these changes and any implications of the recognition of these competencies in legislation. Through the mandatory jurisprudence education program and ongoing web casts on legislative issues and responsibilities, the College has engaged physiotherapists as never before in participating in high numbers in these outreach programs. A similar approach will assist in navigating any questions or educational needs related to the implications of these proposed changes.

The College of Physiotherapists of Ontario has a well established, best practice informed, quality assurance program which is a leading example in the province and nationally. The program will easily adapt to any changes in scope and authorized acts for all physiotherapists and those in extended practice.

The College Quality Management (QM) program recognizes that as self-regulating professionals, they are required to demonstrate competence throughout their careers. This requires continually adapting and upgrading knowledge and skills to keep up with changes in the practice of physiotherapy. The College QM program was established to promote quality practice and to support physiotherapist registrants in their ongoing efforts in applying knowledge, skills, attitudes and judgement, and to ensure the competence of physiotherapists in Ontario. The QM program assists the individual physiotherapist in providing evidence that he or she:

- understands and meets legal and ethical obligations;
- integrates standards into practice;
- conducts self-assessment;
- limits practice according to competence;
- implements best available evidence;
- participates in professional development activities; and
- integrates learning into practice.

Within this the College has a Practice Assessment process that randomly selects participants for peer review, including a review of the participant's knowledge, skills and judgement against set standards

29. How should the College ensure that members maintain competence in this area? How should the College evaluate the membership's competence in this area? What additional demands might be put on the profession?

As described in Question 28, the College has a strong and well accepted QM program in place. The QM Program consists of several components but one is "practice assessment". Elements of practice assessment relevant to the question include:

- by regulation physiotherapists must participate in a random review of their practice - 5% annually
- peer review is well established
- physiotherapy peer assessors are selected through interview and a skills based analysis.
- assessors receive training and are matched to a particular physiotherapist selected for review using set criteria.
- the practice assessment has been rigorously evaluated and demonstrates high levels of reliability and validity in assuring physiotherapists are meeting the standards of practice of the profession.
- with an increased focus in controlled acts and higher risk care, the opportunity exists to focus a portion of the assessment program in this area. As physiotherapists must already declare the controlled acts they are performing at annual registration, it is possible to randomly select from among that group to complete targeted practice assessments in the area of controlled acts.

An individual physiotherapist assessed to be not meeting the controlled act standard would enter into a period of enhancement/remediation to ensure competence. And if an individual physiotherapist was found to be practicing a controlled act without appropriate education, they could either be referred to the Inquiries, Complaints and Reports Committee for an act of professional misconduct or to the Registrar to set terms, conditions and limitations on his/her certificate.

30. Describe any obligations or agreements on trade and mobility that may be affected by the proposed change in scope of practice for the profession. What are your plans to address any trade/mobility issues?

There is no known impact at this time related to current mobility agreements under the AIT. Given that there are different models of legislation across Canada and elsewhere, it is possible that a physiotherapist in another jurisdiction may be practicing in a way that would involve what in Ontario would be considered a controlled act. Such activity might be performed without the kinds of parameters that are set in Ontario by either the RHPA or the College's controlled acts standard. In such circumstances, that are likely remote, a physiotherapist could move to Ontario and still register in Ontario as an independent certificate holder, but could not perform the controlled act until the standard was met. This is not a barrier to movement yet standards are maintained.

Section 9 - Public Education [Question 31]

31. How do you propose to educate or advise the public of this change in scope of practice?

Information packages will be developed in both electronic and paper format which will be circulated to members to share with professional colleagues and patients.

Key stakeholders will be informed directly to update them on physiotherapy roles and capabilities. This will include not only health professional associations and colleges, but also LHIN's, FHT's hospitals, long-term care facilities, Community Care Access Centres and any other settings where physiotherapists work.

Existing channels will be used to advise the public including the College and Association web sites and other public forums.

Section 10 - Other Jurisdictions

[Questions 32-33]

32. What is the experience in other Canadian jurisdictions? Please provide copies of relevant statues and regulations.

While Appendix E provides a more exhaustive description of jurisdictional information, the following serves as a broad based synthesis. Other Canadian jurisdictions vary in terms of how they approach recognizing or authorizing physiotherapy activities that are or have been considered as 'controlled acts' in Ontario. For example, physiotherapy Colleges in the Maritimes have the flexibility to respond to all of the activities under consideration for authorization in this proposal. This is due to the fact that the Maritime provinces do not have umbrella legislation for health professionals and so there is no central list of what are called 'controlled acts' in Ontario.

Findings show that the physiotherapy acts and the college rules themselves determine, with great flexibility, how to respond to emerging areas of expertise that are within the scope of physiotherapy practice. As a result, a number of the activities of physiotherapists are recognized based on the need for evidence of individual knowledge and competency in a given physiotherapist. An example is that ordering MRI, diagnostic ultrasound or x-rays may be done in New Brunswick as long as there is local demand and physiotherapist competence is present. Those activities that are not in 'practice' yet due to local / regional circumstances but could be responded to as justified by the College given the latitude within current rules.

In other provinces, particularly in the west, umbrella legislation for health professionals exists or is in the process of being investigated or developed. As such, there is a central list of 'controlled acts' (also called reserved acts or restricted activities). Colleges in those jurisdictions are addressing these activities through application of College oversight such as requiring evidence of education for the activity, inclusion in a roster and other measures. For some activities, entry to practice competence may be considered sufficient to carry out the activity. In Alberta, the approach is to authorize some restricted activities for entry to practice physiotherapists (e.g. wound care/debridement) while others are addressed through requiring licensed physiotherapists to provide evidence of advanced training approved by the Council and registering (inclusion on roster).

In addition, physiotherapy associations/colleges are engaged in positioning physiotherapists to extend the interprofessional collaborative practice currently found in hospitals and other institutions to the emerging primary health care models.

Physiotherapy College Responses

The upcoming points summarize the kinds of responses received from other Canadian physiotherapy colleges regarding activities of interest to Ontario physiotherapists and this submission.

- Activities Currently Being Sought for Approval in Ontario:

Communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person's symptoms.

- All other provinces are authorized to make and communicate a diagnosis. Most do not further qualify 'diagnosis'. Newfoundland and Labrador, Manitoba and British Columbia define it as a "physiotherapy diagnosis", while Saskatchewan refers to it as 'clinical diagnosis'.

Treating a wound including by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.

- Most provinces authorize this activity with three provinces (Newfoundland and Labrador, PEI and New Brunswick) prepared to support once there is a demand or support for carrying it out.

Administering, by inhalation:

- i. oxygen, or
- ii. a drug or substance that has been ordered by person who is authorized to do so by the Chiropractic Act 1991, the Dentistry Act, 1991, the Medicine Act, 1991 the Nursing Act, 1991 or the Midwifery Act, 1991.

- Most provinces and Canadian military authorize this activity with three provinces (Newfoundland and Labrador, PEI and New Brunswick) prepared to support once there is a demand or support for carrying it out. In Quebec, this is done by Inhalation Therapists.

Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment or treatment

- Most provinces authorize this activity with three provinces (Newfoundland and Labrador, PEI and New Brunswick) prepared to support once there is a demand or support for carrying it out.. BC also requires delegation from a physician. In Alberta, physiotherapists who carry out this activity are on a roster with the College.

Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder,

- i. the application of electromagnetism for magnetic resonance imaging, and
- ii. the application of sound waves for diagnostic ultrasound.

Ordering X-rays

Note: Ordering of x-rays is also included here as it was discussed with other provinces at the same time as ordering MRI and diagnostic ultrasound (this reflects differing legislative models in other provinces)

- There is no consistent approach in Canada. British Columbia physiotherapists may order diagnostic ultrasound. Alberta is currently pursuing authority to order X-Rays and intends to pursue authorization to order MRI's and Diagnostic Ultrasound later. Manitoba is pursuing authorization with a priority on implementation in the north of the province. And New Brunswick allows physiotherapists to order x-rays where local collaboration of physicians, nurses and others along with the physiotherapist agree it is appropriate. In this context, the physiotherapist may order X-rays if competent to do so without delegation. The military is

pursuing authorization. Newfoundland and Labrador and PEI have no demand, but the Colleges would require special certification for a physiotherapist. And Saskatchewan does not authorization at this time.

Ordering lab tests

- None of the jurisdictions currently has authorization to order laboratory tests.

33. What is the experience in other International jurisdictions?

Documentation of physiotherapists' work, initially in providing triage in orthopaedic hospitals in the UK, demonstrates increasing competence and capacity to positively contribute to improving health system operations. There has been growing evidence of positive results from physiotherapists applying current and advanced competencies within new collaborative working relations and approaches in hospitals, the community and primary health care.

The initial move in the US and UK was to establish the recognition of specialists (US) and 'Extended Practice Physiotherapists' (UK) organized within groups such as musculoskeletal. This move was observed and picked up in discussion in Australia, New Zealand and Canada. Australia has extended scope committees at the national and state levels strategizing as to how to support evidence based changes to current practice standards. They have also supported and evaluated a number of physiotherapy initiatives in hospital and primary health care settings similar to the UK.

A parallel initiative on the part of the National Health System (NHS) in the UK, was to establish "Consultant" positions, beginning with nurses and then extended to other practitioners including physiotherapists. Consultant Physiotherapist' positions were established within the Hospital and Primary Care Trusts to assume clinical leadership roles as well as play a role in education and research. A majority of a consultant's time is clinical or in support of clinical activities. They have extended authority in areas such as injections and in ordering x-rays and MRIs. Consultant physiotherapists work with senior medical and nursing colleagues across hospital, community and primary care services in drawing up local care and referral protocols. Those chosen have advanced knowledge, usually in one area such as musculoskeletal and will work with senior medical and nursing colleagues across hospital, community and primary care services in drawing up local care and referral protocols³³.

United Kingdom Evolving - Similarities with Ontario Request

The Chartered Society of Physiotherapists (CSP) just completed a review of scope of practice and released an information paper on Scope of Physiotherapy in 2008³⁴ that provides greater flexibility for physiotherapists to configure their practices and signals a move away from extended scope physiotherapist and toward a system that will recognize additional relevant training and competencies as physiotherapists develop them in accordance with professional advancement and in relationship to local need. The move from extended scope physiotherapist is proposed for a number of reasons including:

- Insurance companies raised questions about insurance for practices perceived or suggested as being beyond the scope of practice of a physiotherapist; and
- The CSP determined that some physiotherapists thought that some of what they were doing

³³ Chartered Society of Physiotherapy, 2002

³⁴ Chartered Society of Physiotherapy, 2008

was beyond their scope - which was in error.

The CSP asserted that it is the final arbiter of whether a physiotherapist was working within their scope - providing there is evidence of skills and competencies to undertake the role. They further clarified that the notion of extended work beyond entry to practice had more to do with breadth of scope and specialist work than about drilling down in a specific area.

The definition of physiotherapy from the CSP recognizes four pillars of practice and provides the CSP with flexibility to recognize advanced competency for any physiotherapist. The first three: massage; exercise and movement; and electrotherapy are narrowly related to specific treatment intervention. The fourth pillar, kindred methods of treatment, is suitably broad to allow physiotherapists to expand their expertise according to patient need. Similarly, the curriculum framework includes the statement "committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery" also acknowledges an evolving profession developing new knowledge and practice realities.

While acknowledging that physiotherapists do work in a variety of population specific or sectoral settings, the CSP acknowledges changing practices where physiotherapists are able "to expand their competence and capability for the benefit of patient care. Through innovative practice physiotherapists are able to extend treatment options available to their patients." The CSP now defines scope of practice as: "...any activity undertaken by an individual physiotherapist that may be situated within the four pillars of physiotherapy practice where the individual is educated, trained and competent to perform that activity. Such activities should be linked to existing or emerging occupational and/or practice frameworks acknowledged by the profession, and be supported by a body of evidence."

In keeping with the proposed direction for Ontario, physiotherapists in the UK will be able define and practice within their own scope of practice with possibly unique elements. The CSP acknowledges that both undergraduate and post-graduate education provides the foundation for physiotherapists to deliver a variety of services. The CSP now recognizes an individual scope of practice of individual physiotherapists that can be configured a variety of ways. From the CSP, the practice must be lawful and reasonable. The CSP will assess physiotherapists when required (e.g. response to complaint) through confirmation that the individual was working within their personal scope of practice and providing there is evidence of the individual's competence to undertake the role/activity in question, and that the activity sits within the four pillars.

United Kingdom - Relationship to Ontario's Requested Authorized Acts

All of the following are authorized either at entry to practice or for individuals working at an extended level of work with appropriate education, experience, competence:

- Communicating a diagnosis - entry
(Note: this was also the case in Australia, New Zealand and the US)
- Wound care/debridement - extended
- Administering Oxygen / titration - entry
- Putting an instrument/hand/finger beyond the labia majora or anal verge for assessment / treatment (e.g. incontinence) - extended
- Setting/casting a fractured bone or dislocation of an extremity - extended
- Ordering X-Rays, MRI, Diagnostic Ultrasound, Bone Scan, Myography- extended
- Aspirating fluid from a joint - extended

- Prescribing drugs - extended - but within what is called 'supplementary' prescribing where physiotherapist must develop a Clinical Management Plan in concert with a physician with the patient's agreement including agreement on what drugs the physiotherapist would be allowed to prescribe³⁵. The CPS is working toward authorization for independent prescribing.

Section 11 - Costs/Benefits

[Question 34]

34. What are the potential costs and benefits to the public and the profession in allowing this change in scope of practice? Please consider and describe the impact of any of the following economic factors:

Direct patient benefits/costs

With the improvement in scope of practice and access to additional authorized acts, physiotherapists will be better positioned to enhance their potential to provide timely access to appropriate assessment and treatment for the public who choose them. With the existing barriers removed, the public should ultimately experience increased access to and benefit from physiotherapy services.

The public will benefit from physiotherapists' participation in their care planning and goals and from receiving a diagnosis which should increase the patient / professional relationship and trust. Physiotherapists in this context would be able to provide more timely completion of forms and communications with payers to ensure that patients can access their benefits.

Patients will appreciate reduced costs associated with displacement, lost time to attend additional appointments required to receive orders, directives, referrals for communication of diagnosis, accessing treatment that would require titration of oxygen (re-activation, mobilization of those with chronic respiratory conditions), assessment and treatment of incontinence, wound care in the community. The economic burden that can impact on patients and their informal caregivers was illustrated in Question 17 (d).

The effectiveness of care means fewer complications and greater potential for patients to have improved quality of life and ability to be productive.

As stated in a recent Ontario study: "Health professionals, such as physiotherapists, occupational therapists and nurses with advanced skills and training who work - - in an interdisciplinary team, have the potential to facilitate timely and appropriate access to the right provider for people with arthritis and musculoskeletal conditions". Further, this study observed that utilization of such providers "in primary care for patients with musculoskeletal complaints and throughout the continuum of care for people with all types and severity of arthritis has the potential to improve access to care by the right provider and ultimately improve patient and system level outcomes"³⁶.

Another study of primary care physiotherapists responding to musculoskeletal soft tissue injuries demonstrated they were effective at producing functional outcomes particularly where there were delays in receiving physiotherapy treatment beyond three days after injury and when able to respond in a timely fashion to significantly reduce time loss-from-work³⁷.

³⁵ Department of Health (UD) 2005

³⁶ Davis, Aileen M., Crystal MacKay and Elizabeth M. Badley 2008

³⁷ Fenety, Anne and Tanya Nichol 2007

Patients are satisfied with the services of physiotherapists with additional expertise as documented in numerous studies (two are cited)^{38 39}.

- **Benefits and costs to the broader health care services delivery system**

Permitting the changes will result in the enhanced capacity of physiotherapists to contribute in interprofessional collaboration given the removal of some of the barriers they now face to maximizing their personal competencies in the service of the public and in a complementary way to their associated teams. Other professionals on health teams will better appreciate and understand the physiotherapy role, scope, competencies and accountability to improve collaborative and inter-supportive work. This should enhance and support the potential of new primary health care models and approaches. And it should reinforce and facilitate replication of successful hospital based programs (e.g. orthopaedic triage). In one study it was demonstrated that physiotherapists treating musculoskeletal soft tissue injuries can fulfil many primary health care roles, including consultation in primary health care offices and providing early intervention clinics⁴⁰ .

Physician's satisfaction with the physiotherapy extended roles has been documented in a number of studies. In the Netherlands, family physicians were very satisfied with their physiotherapy consultations and changed their management in almost 50% of the cases they referred⁴¹ .

Increased access to non-pharmaceutical approaches to incontinence issues for both men (e.g. post-prostate cancer) and women – reduced pharmaceutical costs. A recent study found that 82 percent of women were cured of stress urinary incontinence after one episode of physiotherapy care and a further study found that physiotherapy management of female stress urinary incontinence costs an average of \$302.40 while surgical management costs between \$4668 and \$6124⁴² .

Cost savings in the system have been have been documented as result of new organizational configurations with physiotherapists and application of expertise.

A Kingston study found that physiotherapists and orthopaedic surgeons make similar conclusions about the post-operative functional status of patients and that physiotherapists can manage the majority of patients alone. This model presented more conservative treatment options to patients and presented time savings to the surgeons to allow them to spend more time in the operating room⁴³ . Physiotherapists providing triage in orthopaedic clinics has resulted in increasing documentation of savings. In one study, physiotherapists generated lower initial direct hospital costs as they were less likely to order radiographs and refer patients to orthopaedic surgery⁴⁴ . In a case study of collaborative musculoskeletal interface service in Somerset, physiotherapists with extended competencies contributed to savings of £700 per patient due to lower conversion rates to surgery than local orthopaedic departments while maintaining high patient satisfaction⁴⁵ . And a randomised trial demonstrated that the use of specially trained physiotherapists working in an extended role (orthopaedic physiotherapy specialist) were as effective as post-fellowship junior staff and clinical assistant orthopaedic surgeons in the initial assessment and management of new referrals to

38 Daker-White et al 1999

39 Robertson, Val J., Leonie B. Oldmeadow, Jean E. Cromie and Margaret J. Grant 2003

40 Fenety, Anne and Tanya Nichol 2007

41 Hendricks, H.J.M. et al 2003

42 Australia Physiotherapy Association 2005 *The Health Workforce*

43 Aiken, Alice B., Marg Atkinson, Mark M. Harrison and John Hope 2007

44 Daker-White et al 1999

45 Department of Health (UK) 2006

outpatient orthopaedic departments and generate lower initial direct hospital costs⁴⁶ .

Physiotherapists will be allowed to work to the maximum of their scope as they do in most provinces in Canada which should support improved recruitment and retention of professionals who are interested in developing their career into areas where their physiotherapy competencies can evolve – career laddering, recognition of skills and contribution.

- **Benefits and costs associated with wait times**

Physiotherapists working in extended roles in triage of orthopaedic clinics have demonstrated decreases in waiting times. The Alberta Bone and Joint Institute achieved “a decline of approximately 80% in consulting waiting time, a decline of almost 90% in surgery waiting times and a decline of 30% in hospital stay with no increased costs per case from the time of referral to discharge from the hospital”⁴⁷ .

An Australian study using physiotherapists with extended competencies in the emergency room, reduced waiting times and total treatment time for patients presenting with musculoskeletal injuries⁴⁸ . While another Australian study with physiotherapists providing triage achieved dramatic decreases in patient waiting times to see an orthopaedic surgeon from 93.4 days to 17.6 days⁴⁹ .

- **Workload, training and development costs**

There should be no changes to workload, training or development costs for the changes to the scope of practice that is requested since the physiotherapists have the training and competencies and this process will simply remove some of the barriers to optimizing their competence.

For physiotherapists accessing post-graduate programs to prepare to qualify for the additional authorized acts, the costs should be similar to those currently seeking post-graduate qualifications.

There will be development costs associated with the ongoing evolution of education programs associated with the additional authorized acts. However, ongoing curriculum updates are now part of the current environment, so some of the costs are already in place.

Costs associated with educational and regulatory sector involvement

The educational sector will be better able to prepare and advance curriculum with reference to a scope of practice that reflects actual practice and on additional authorized acts that are in keeping

with the requirements of the health system needs and the current and evolving needs of an aging population.

There are minimal regulatory changes needed to meet the proposed model. Costs associated with this would not be different than what applies now to the current scope of practice and two authorized acts currently held by the physiotherapy profession.

46 Daker-White et al 1999

47 Alberta Bone and Joint Institute 2005

48 Australian Physiotherapy Association 2005 Submission - WA Branch

49 Australian Physiotherapy Association Queensland Branch 2005

Section 12 - Other Information and Conclusion

[Question 35]

35. Is there any other relevant information that HPRAC should consider when reviewing your proposal for a change in scope of practice?

Potential Future Options for Consideration

As populations are aging and living longer, profiles of need have evolved to include multiple and more complex chronic diseases. These must be addressed by a health system now struggling with shortages of health professionals. Maximizing the capacity of all health resources, especially personnel, is essential. This involves a delicate balance between serving day to day needs while working to achieve systemic reform, while also reaching out to new opportunities implicit in new technologies and research results pointing to more favorable directions.

These conditions have served to accelerate the evolution of roles and responsibilities of health professionals in general, and physiotherapists in particular, who work throughout the health system in a wide range of roles and settings across the continuum of care. Physiotherapists' competencies and experience have emerged in a number of new evolving roles (in roles under delegation but mostly in other jurisdictions), responding to population needs. This experience holds promise to enhance Ontario's existing and future system capacity.

With a responsible eye to the future, and the need to maximize all resources to serve patient needs and system effectiveness, it would benefit Ontario to give future consideration to affording the following additional authorized acts to physiotherapists:

- Setting or casting a fracture of a bone or a dislocation of a joint,
- Applying or ordering the application of electricity for electromyography and nerve conductive studies
- Medication management after initial order

The merits of each are reviewed below.

- **Setting or casting a fracture of a bone or a dislocation of a joint when: the fracture or dislocation of a bone or joint in an extremity, and the fracture or dislocation is set without the use of surgical technique.**

Physiotherapy entry to practice curriculum provides a solid underpinning in anatomy, physiology and healing principles of bone. Authorization for setting or casting a fracture of a bone is not currently done in Ontario. Alberta has authorization for demonstrably competent physiotherapists set or cast a fracture of a bone or dislocation.

Examples of this work by physiotherapists in other jurisdictions, such as the UK, have demonstrated that there is no significant difference between the diagnosis, x-ray interpretation and management between physiotherapists and physicians. However, there is currently no training for this in Ontario or Canada, and mechanisms for competency evaluation will need to be developed as part of the post-graduate training. As a result, setting fractures may be an appropriate authorized act for physiotherapists in Ontario in the future based on evaluation of the environment related to need and the potential development of skills.

- **Applying or ordering the application of electricity for electromyography and nerve conductive studies**

Physiotherapy entry to practice includes high-level principles about motor and sensory nerve function. Additionally, diseases that affect peripheral nerves, the signs and symptoms of impaired nerve function and diagnostic testing are presented with the principles of nerve recovery. However, there are no known examples of a physiotherapist practicing clinically (not in research) ordering or performing these acts in Ontario in circumstances where needles are used, although Alberta does authorize this act.

Competency and evaluation mechanisms would need to be established in conjunction with post-graduate training to provide confidence in this activity. The authority to order and perform such studies would be beneficial in primary care and orthopaedic settings to expedite care for patients.

- **Prescribing Drugs/Medication management after initial order**

Physiotherapy entry to practice education includes content regarding types of drugs used in diseases that affect the neuromuscular, musculoskeletal and cardiorespiratory systems. There are currently no known examples of a physiotherapist doing initial prescription of drugs in Ontario, although some physiotherapists perform elements of medication management (e.g., adjusting dosage) under directives in collaborative health care. The American military physiotherapists with demonstrable competence based on pharmacology education are allowed to prescribe over-the-counter analgesics, prescription muscle relaxants and non-steroidal anti-inflammatory drugs (NSAIDs). The Canadian military intends to pursue similar authorization for its physiotherapists.

As is more fully described in Appendix A, entry to practice curricula in Ontario university programs includes pharmacology content regarding medications used in management of disorders of the neuromuscular, musculoskeletal, or cardiorespiratory systems. This entry to practice curricula could serve as a base for post-graduate education regarding indications, contra-indications, dosages, side effects and other relevant knowledge sufficient for more physiotherapists to develop competency at medication management in specific situations. As a result, it may be appropriate to consider future roles for physiotherapists that develop and demonstrate competency to be involved in medication management for patients with acute or chronic disorders of the musculoskeletal, cardiorespiratory or neurological systems. For example, the sorts of medications for which it may be relevant to involve physiotherapists in management include non-opiate analgesic drugs (e.g., Tylenol), non-steroidal anti-inflammatory drugs (e.g., Naproxen), bronchodilators (e.g., Ventolin) and anti-spastic (e.g., Baclofen) and anti-parkinsonian drugs (e.g., Sinemet, Requip).

Final comment on the model

The project partners determined, based on the evidence and the current evolving practice of physiotherapy, that the use of an extended class registration has the potential to limit the flexibility and responsiveness associated with permitting physiotherapists to practice to the full extent of their competence within scope. However, should HPRAC be interested in entertaining a model that is based on different registration categories, the project partners would be pleased to discuss elements of such a model in more detail.

Conclusion

The profession of physiotherapy is a significant team player in the delivery of safe, quality care to Ontarians. This review is an opportunity to consider, within our legislative model, the best way in which to optimize the skill set that physiotherapists have to contribute to the health system and its goals. Based on evidence which has focused on the profession's current competencies seen in practice, education and competence assessment, this submission seeks change. The proposed changes to the scope statement and authorized acts are grounded in the literature, the reality of the practice environment, national and international trends and the government's health care goals.

The profession looks forward to discussing this submission with HPRAC and is committed to being a willing player in all dialogues or potential options that will realize the fullest contribution that physiotherapists can make to collaborative, patient-centred care.

Physiotherapy Scope of Practice Review

Appendix A

*Evidence to support the proposals for revisions to controlled acts
authorized to physiotherapists and other statutory provisions related
to physiotherapists' competencies: current and future*

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About sources and the process of gathering evidence

Evidence was gathered through consultation with academic physiotherapists, administrators and physiotherapists working in the hospital, community and private practice. Academic physiotherapists provided input of two types: (i) all five Ontario programs were invited to contribute entry to practice curriculum examples and frameworks, and all five program chairs/directors expressed their support of the approach being undertaken in constructing this submission; (ii) academic physiotherapists who have roles in research and teaching in relation to advanced practice roles were invited to contribute their expert perspectives and guide the process of gathering other evidence. As a result of the latter and the consultations with administrators and physiotherapists working in hospital, community and private practice settings, relevant published and grey literature sources were identified as well as relevant documents from organizations and committees that support the training, evaluation of competencies and profession of physiotherapy.

The reader should note that the evidence gathered and presented in this Appendix A and in Appendices B and C is focused on certain aspects of the proposals in the current submission and not others. Specifically, the evidence presented supports the proposed revisions to controlled acts authorized to physiotherapists and the proposed statutory provisions governing the ordering of diagnostic tests. In addition, evidence is presented to inform the reader of potential future revisions to controlled acts and statutory provisions. All of these areas are concerned with a physiotherapist's competencies at procedures that may be involved in the assessment and treatment of individual patients who come to be under their care. The underpinnings for these competencies are based in entry to practice and post-graduate education.

This Appendix (A) and Appendices B and C do not present evidence for the other proposed statutory revisions, such as those proposed for the Public Hospitals Act and the Health Insurance Act. The rationale for those revisions is based on optimizing physiotherapists' ability to contribute to health care systems rather than on specific assessment and treatment skills. Moreover, these appendices do not discuss any revisions that would be needed to other statutory provisions to enable the realization of the proposed revisions. While we recognize that many such revisions may be necessary – e.g., revision of the acts governing other regulated health professionals to make it possible for them to act on a physiotherapist's order for a diagnostic test – those revisions would be guided by the interrelationships among elements of legislation and regulation rather than directly by evidence of physiotherapists' competencies.

About the structure of the presentation of the evidence

The evidence presented in this appendix is structured in three sections:

1. Evidence for the proposed revisions to controlled acts authorized to physiotherapists;
2. Evidence for the proposed revisions to other statutory provisions related to diagnostic tests:
 - to the Healing Arts Radiation Protection Act; and
 - to the Laboratory and Specimen Collection Centre Licensing Act;
3. Evidence for potential future revisions to authorized controlled acts and statutory provisions

For sections 1 and 2, each proposed revision is identified, followed by subsections entitled Current practice, Education and Competency Evaluation. Note that some evidence from other jurisdictions is included but the reader is invited to consult Appendix E for a more complete jurisdictional review. Section 3 discusses evolving areas of physiotherapy practice and how they may in future be constrained by current legislation.

1. Evidence for the proposed revisions to controlled acts authorized to physiotherapists

Table A1 provides an overview to show where there is educational support at the entry to practice and post-graduate levels for each proposed new controlled act. As seen in Table A1, two of the proposed controlled acts – communicating a diagnosis and administering oxygen – are fully included in the entry to practice curriculum with corresponding competency evaluation. All other proposed new controlled acts have some elements of their education included in entry to practice programs (“partially”) and the remainder of the education and competency testing is obtained through post-graduate education.

Table A1: Education support for the proposed new controlled acts

Proposed New Controlled Acts	Education	
	Entry to practice	Post-graduate level
1. Communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person’s symptoms.	yes	yes
2. Treating a wound including by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.	partially	yes
3. Administering, by inhalation:		
i. oxygen, or	yes	not applicable
ii. a drug or substance that has been ordered by a person who is authorized to do so by the Chiropractic Act 1991; the Dentistry Act, 1991; the Medicine Act, 1991; the Nursing Act, 1991; or, the Midwifery Act, 1991.	partially	yes
4. Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment or treatment.	partially	yes
5. Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder,		
iii. the application of electromagnetism for magnetic resonance imaging.	partially	yes
iv. the application of sound waves for diagnostic ultrasound.	partially	yes

Proposed Controlled Act 1

Communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person’s symptoms.

Current Practice:

Currently, physiotherapists in Ontario assess and establish a diagnosis within their scope of practice. As will be described below, entry to practice education follows national standards, all of which describe that competency at diagnosis within physiotherapists’ scope of practice is essential. Thus, at graduation, physiotherapists are prepared to work in the other nine Canadian provinces in which physiotherapists are authorized to communicate a diagnosis. However practice in Ontario is restricted by the absence of the controlled act of ‘Communicating a Diagnosis’ within the Physiotherapy Act. Physiotherapists communicate the results of their assessment without offering a diagnosis, refer the patient to another health profession to receive a diagnosis or use words such as ‘clinical impression’ to frame their communications in this area. This situation compromises physiotherapists’ ability

to provide the rationale for treatment to patients, engage patients in treatment planning and subsequently obtain informed consent for treatment. Thus, patient care is compromised particularly in the community, such as in home care and private practice, where patients seek care from physiotherapists through primary access.

A physiotherapist's diagnosis of a patient would be intrinsic to a scope of practice based on assessment of neuromuscular, musculoskeletal and cardiorespiratory systems. In some cases, a physiotherapist's diagnosis may differ from those of other regulated health professionals but be entirely appropriate and within scope of practice. For example, a patient with a long history of major mental health disorder may present with distress arising from medication side effects. A psychologist may diagnose a specific psychologically based psychotic disorder while a physiotherapist may diagnose tardive dyskinesia. The diagnoses are not incompatible, merely focused on different systems. On the other hand, physiotherapists' diagnoses would be expected to be similar or identical to those of other regulated health professionals when focused on assessment of the same systems. There is evidence to show that this is indeed the case, and this is presented below under Competency Evaluation.

Education:

Academic physiotherapy leaders in Ontario – i.e., the directors/chairs of master's programs in physical therapy at University of Ottawa, Queen's University, University of Toronto, McMaster University, University of Western Ontario – unanimously agree that their entry-level curricula includes training and evaluation of the determination of a differential diagnosis. As presented in the response to Question #26 in the submission, competency at diagnosis within physiotherapy scope of practice is a core element in curricula and could not be deficient without serious consequences for an academic program's success at maintaining accreditation and having its graduates succeed in Canadian contexts. Appendix B provides an overview of how Ontario academic programs incorporate diagnosis throughout the entry-level curriculum.

Competency Evaluation:

For evaluating physiotherapy students' performance in clinical education, all Ontario entry to practice programs (and most in Canada) use the Clinical Performance Instrument¹. Students' performance is judged on multiple criteria of which one is "Evaluates clinical findings to determine physical therapy diagnoses and outcomes of care." Sample behaviours within this criteria include the following: interprets clinical findings to establish a diagnosis within the practitioner's knowledge base; identifies competing diagnoses which must be ruled out to establish a diagnosis; and uses clinical findings and diagnosis to establish a prognosis within the practitioner's knowledge base.

Following completion of the entry to practice academic and clinical education, physiotherapists must successfully complete the national Physiotherapy Competency Examination in order to become registered physiotherapists in Ontario. The Physiotherapy Competency Examination is competency based and its content is based on the same documents as described for entry to practice education as well as their own Analysis of Practice², which guides the development of the Exam Blueprint³.

A review of the literature demonstrates that physiotherapists' diagnoses for patients with musculoskeletal complaints correspond to surgeons' diagnoses. An Ontario-based study

1 American Physical Therapy Association (APTA) 1997, "Physical Therapist Clinical Performance Instrument", APTA Division of Education, Alexandria, Virginia

2 Canadian Alliance of Physiotherapy Regulators 2008, "Analysis of Practice 2008", review of recommended changes to the Physiotherapy Competency Examination Blueprint (draft) (Available from the College of Physiotherapists of Ontario)

3 Canadian Alliance of Physiotherapy Regulators 2005, Physiotherapy Competency Examination Blueprint

demonstrated that there was 95% agreement in diagnosis of patients with knee and shoulder complaints between physiotherapists and orthopaedic surgeons.⁴ A study from Britain demonstrated that the diagnostic accuracy of physiotherapists compared to consultant orthopaedic surgeons was between 94 and 98% depending on the diagnosis in new patients attending an acute knee injury clinic. In this study, the gold standard for diagnosis was determined by arthroscopy.⁵ A study from the United States similarly showed that physiotherapists seeing musculoskeletal patients in a primary care setting agreed with the orthopaedic surgeon's diagnosis 90.9% of the time.⁶

In summary, there is strong evidence in current practice, current education and current evaluation of the competency of determining a differential diagnosis for physiotherapists within their scope of practice.

Proposed Controlled Act 2

Treating a wound including by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.

Current Practice:

Under current entry-level competencies, physiotherapists in Ontario are involved in wound care for patients who have experienced burns, chronic wounds as a result of pressure and tissue breakdown, diabetic foot ulcers or acute wounds as a result of surgery or injury. Physiotherapists use therapeutic modalities such as energy in the form of electrical stimulation or laser or therapeutic sound waves which are recommended treatment for wound care in Canadian provincial and national clinical practice guidelines.⁷ However, currently physiotherapists in Ontario are not authorized to perform any component of the controlled act that includes procedures below the dermis. Therefore, physiotherapists in Ontario must rely on other health professionals to cleanse, soak, irrigate, probe, debride, pack or dress a wound. However, consultation with individuals who have a focused practice in wound care revealed that the physiotherapists who perform these procedures under delegation have developed these additional competencies through post-graduate training that built on their entry to practice education.

When physiotherapists are unable to perform these procedures, system inefficiencies occur and potentially leave the patient at risk for infection if a wound must be left exposed until another health professional is able to dress the wound. This is particularly problematic in community settings including home care where wound care requires both a physiotherapist and nurse to provide care in a tightly coordinated manner. The authorization for physiotherapists who have demonstrated competency at these procedures to perform them without need for directive or delegation would help address the large need for service for people with ulcers related to diabetes and other chronic health disorders who are "aging at home."⁸

Education:

The current entry to practice physiotherapy curricula in all Ontario university programs provides theoretical and practical skills that can be applied in wound care (see Appendix B) that position physiotherapists well for additional skill acquisition through post-graduate training. Assessment of skin integrity and wounds and the basis and applications of therapeutic energy modalities are

4 Aiken, A. B. and M. A. McColl 2008, *Journal of Interprofessional Care*

5 Dickens, V., F. Ali, et al. 2003, *Physiotherapy*

6 Moore, J. H., D. L. Goss, et al 2005. *Journal of Orthopaedic & Sports Physical Therapy*

7 Graham, Harrison, Lorimer et al. 2005, *Advances in Skin & Wound Care*

8 Ontario Ministry of Health and Long-term Care (MoHLTC) 2007, "Aging at Home Strategy", http://www.health.gov.on.ca/english/public/program/ltc/33_ontario_strategy.html

included in entry-level curriculum.

Consultation with the profession which included those with and without a focus in wound care unanimously indicated that additional training at the post-graduate level was required to develop competency for full independent practice in all procedures identified within the proposed controlled act. Currently, two Ontario-based programs have been identified that provide this post-graduate training, one at University of Toronto and the other at University of Western Ontario.⁹ See Appendix C for full contact information. Both programs include theoretical and practical components. In addition, physiotherapists may develop competency at wound care procedures within less formalized education, such as has been the case for many physiotherapists currently doing these procedures under delegation or directive.

Competency Evaluation:

Evaluation of basic knowledge and skills of patient care related to wounds currently occurs within the entry to practice academic programs. Graduates of those programs must undertake the national Physiotherapy Competency Examination in order to become registered physiotherapists in Ontario. The Exam Blueprint¹⁰ lists the following relevant examination elements:

- sample areas of practice includes “dermal conditions (e.g., decubitus ulcers, burns)” and “peripheral vascular disease”
- assessment and evaluation includes “evaluate/assess status of skin”
- intervention includes therapeutic energy modalities applicable to wound care as well as “scar management techniques”

The procedures of “perform wound cleansing and debride wounds” are listed as an advanced acquisition activity and currently are not evaluated in examination. This is in keeping with the approach that the requested authorized acts would be performed by those with post-graduate training and demonstrated competencies.

Evaluation of wound care competencies is included in the advanced training programs at the University of Western Ontario and the University of Toronto such that a Masters degree is awarded. Additionally, certification in wound care can be obtained from courses such as the International Interdisciplinary Wound Care Course (IIWCC); Enterostomal Therapy (CAET, WCCn), Plastic Surgery, and Dermatology courses.

In summary, the proposed controlled act related to wound care is supported in current practice and through a combination of entry to practice and post-graduate education and competency evaluation.

Proposed Controlled Act 3

Administering, by inhalation:

- i. oxygen, or
- ii. a drug or substance that has been ordered by a person who is authorized to do so by the Chiropody Act 1991; the Dentistry Act, 1991; the Medicine Act, 1991; the Nursing Act, 1991; or, the Midwifery Act, 1991.

Current Practice:

Physiotherapists currently are restricted from administering oxygen to maintain a patient’s blood

⁹ University of Toronto: http://www.phs.utoronto.ca/MScCH_WPC.asp and University of Western Ontario: http://www.uwo.ca/fhs/pt/prospective/mclsc/wound_healing.html

¹⁰ Canadian Alliance of Physiotherapy Regulators 2005, Physiotherapy Competency Examination Blueprint

oxygen saturation levels at a level prescribed by health professionals with prescribing authority. This is despite the fact that the physiotherapists having the authority to perform the controlled act of tracheal suctioning. Oxygen levels often decrease when tracheal suctioning is performed to clear secretions. Administration of oxygen is then required to maintain the patient's blood oxygen saturation level but another health professional must administer the oxygen. In the case where a patient has increased oxygen demands when walking or performing exercises under the supervision of a physiotherapist, another health professional similarly must be present to administer oxygen.

A recent survey indicated that oxygen was used in 62 of 172 hospitals surveyed. In 48 of these 62 hospitals, administration of oxygen had been delegated to physiotherapists.¹¹ Consultation with physiotherapists and managers in selected specific institutions supported the conclusions of this survey. For example, the Ottawa Hospital, Hamilton Health Sciences Centre and University Health Network in Toronto all are academic tertiary care centers in which delegation occurs.

Physiotherapists are required to administer oxygen during weekend coverage when respiratory therapy staff are not available or in smaller community hospitals in which there may be less flexibility in the deployment of personnel skills/resources. Outside of hospitals, many patients in the community have oxygen prescribed and may require administration of oxygen if blood oxygen saturation levels decrease during physiotherapy treatment. A physiotherapist working in home and community settings with such patients must either ensure that another health professional is present who is authorized to administer oxygen or undertake activities of a lower level of exertion that may be less optimal for the patient's rehabilitation to better health.

People with impaired ventilation due to respiratory conditions such as asthma or tenacious secretions may benefit from an inhaled drug (e.g. Beclovent etc.). These drugs are often administered in conjunction with a physiotherapist's interventions aimed at facilitating secretion removal and improve ventilation. However, physiotherapists are restricted in administering drugs currently such that another health professional, usually a nurse or respiratory therapist, must administer the drug dosage into the mask that will be applied for the treatment. This results in inefficiencies in care similar to those described above for oxygen.

Education:

The physiotherapy entry to practice curricula in all Ontario university programs includes content related to the administration of oxygen (see Appendix B). Numerous examples exist from these programs. However, the description from a professor at the University of Western Ontario describing the class on Oxygen Therapy in Acute Care II encapsulates the material: "... includes short term/acute and long term/chronic administration, indications, contraindications, side effects, 'dosage', methods of administration, supplies of oxygen (liquid, gaseous, concentrator), mechanisms of hypoxemia and effectiveness of oxygen therapy etc All of this builds on materials already taught with respect to gas exchange, oxygen transport, and determination of adequacy of oxygenation in any one patient (including hemoglobin, cardiac function/output, perfusion pressure, tissue conditions etc.)". The entry to practice curricula also include content related to the administration of inhaled drugs for cardiorespiratory conditions (see Appendix B). Specifically, the pharmacology and indications for inhaled drugs that affect respiratory status and for which timing of dosage is relevant to secretion clearance and exercise are included in the curricula.

The inclusion of administration of oxygen and other inhaled drugs in entry to practice curricula is reflected by their inclusion in the most recent Canadian curriculum guidelines for entry to practice

¹¹ Espiritu, O., E. Schaeffer, et al. 2008

physiotherapy education.¹² Within the sections pertaining to the cardiorespiratory system, the guidelines recommend inclusion of knowledge related to therapeutic dosage, indications, contraindications and general effects of drugs on cardiorespiratory function, as well as skills in pulse oximetry, and “medication delivery (e.g., oxygen)”.

Given that medical directives/delegation of authority is currently in place in many institutions, institutional-based education programs also exist. In some cases this involves a lecture by a respiratory therapist and practical demonstration prior to competency evaluation. In other cases, consultation revealed that institutions had self-learning modules. In all cases the education programs in place to meet the requirements of the medical directives/delegation of authority represent a duplication of the education already held by physiotherapists through their entry level education programs, particularly for the administration of oxygen.

Competency Evaluation:

At the entry- to-practice training level, administration of oxygen and other inhaled drugs is evaluated (see Appendix B). Additionally, evaluation is included in the national Physiotherapy Competency Examination; in the Exam Blueprint¹³ one of the elements listed under Interventions is “administer oxygen as prescribed”.

In the case of therapists practicing under medical directive, evaluation of competency is specific to the institution. Consultation identified that the process for certification most frequently was self-study examination followed by practical application with signing of the medical directive by a respiratory therapists upon demonstration of proficiency.

In summary, the evidence is strong that administration of oxygen and other inhaled substances is an entry-level competency held by physiotherapists.

Proposed Controlled Act 4

Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment or treatment.

Current Practice:

Urinary and fecal incontinence is an increasingly common problem as the proportion of older adults in the population increases. It can occur post partum, from pelvic organ prolapse, following surgery for prostate cancer or in lesions of the spinal cord or cauda equina. Physiotherapy treatment techniques such as muscle retraining through electrical stimulation and biofeedback and pelvic floor exercises are part of current best practice guidelines (Lacima and Pera 2003).¹⁴ Additionally, these techniques can be beneficial for people with dyspareunia where there is pelvic pain. These areas of practice are becoming more common for physiotherapists in Ontario who have post-graduate training and, in fact, internationally recognized experts in the education of physiotherapists working in this area and in treatment are located in Quebec.

The proposed controlled act is requisite for assessment and treatment of the conditions described

12 Canadian Universities Physical Therapy Academic Programs (CUPAC). Entry to practice Physiotherapy Curriculum: Content Guidelines for Canadian Academic Programs. Draft approved in principle by CUPAC, May 2008. The penultimate draft was approved in principle and the final document is expected to be public later in 2008. These curriculum guidelines replace the previous Canadian guidelines published in 1995.

13 Canadian Alliance of Physiotherapy Regulators 2005, Physiotherapy Competency Examination Blueprint

14 Lacima G. and M. Pera 2003, *Current Opinions in Obstetric Gynecology*

above. Assessment and exercise techniques for these conditions are analogous to the use of palpation techniques on surface muscles to determine if the muscle is contracting. The difference is that access via the vagina or rectum is necessary to palpate the pelvic floor musculature. A large number of the patients who seek health services for such problems do so through community settings such as outpatient clinics. A physiotherapist with competency at this act may be sought after to provide service to many community patients but must seek medical delegation from each patient's physician in order to provide the assessment and treatment, frequently resulting in unnecessary delays.

Education:

Physiotherapy entry to practice education includes the necessary theoretical basis for assessment and treatment as well as practical experience in the commonly used treatment modalities of biofeedback and electrical stimulation and pelvic floor exercises (see Appendix B). Consultation with the physiotherapists who work in this area all agreed that these were entry-level competencies that positioned physiotherapists to easily acquire the additional assessment and treatment skills through short post-graduate courses.

Individuals with internationally recognized expertise work in Quebec, and these same individuals offer weekend courses at which physiotherapists gain additional knowledge and skills. All individuals consulted for this evidence review had trained with the same three individuals from Quebec. The courses include theoretical and practical education in assessment and treatment.

Competency Evaluation:

Currently, competency evaluation occurs at entry to practice education in academic programs only in the context of the theoretical and practical use of biofeedback and electrical stimulation and pelvic floor exercises. There is not direct evaluation in relation to the proposed controlled act.

The assessment skills and application of treatment techniques are part of post-graduate education. Post-graduate training courses are structured for peer-to-peer feedback as well as instructor feedback throughout the course.

In summary, a combination of entry to practice education and post-graduate training provides physiotherapists with competency to perform the proposed controlled act

Proposed Controlled Act 5

Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder,

- i. the application of electromagnetism for magnetic resonance imaging, and**
- ii. the application of sound waves for diagnostic ultrasound.**

Current Practice Regarding Magnetic Resonance Imaging:

Physiotherapists in Ontario are currently order magnetic resonance imaging (MRI) under medical directives. In most instances, these directives have been imparted to individuals working in the area of musculoskeletal disease and spinal clinics. For example, a physiotherapist might order an MRI when a meniscal tear or anterior cruciate ligament tear is suspected in a knee or if a spinal disc herniation is suspected. The authority to order such diagnostic tests would enhance system efficiencies by eliminating the need for a patient to see multiple health care providers. Many people with the types of injuries indicated here require conservative management, mainly rehabilitation that is provided by a physiotherapist to ameliorate physical dysfunction and pain and promote mobility. Many of these individuals could be assessed and treated by a physiotherapist with referral to specialist care only in

selected cases (e.g. concomitant fracture, combination injuries of the knee such as two ligament tears and a meniscal tear, disc herniation in which there is spinal cord compression).

Physiotherapists in the United States army and those working in consultant roles in the United Kingdom are also able to order these diagnostic tests.^{15,16,17} In a study of the appropriateness of MRI ordering, the authors found that the physiotherapists' referrals for MRI were appropriate 100% of the time when reviewed independently by an orthopaedic surgeon and a radiologist.¹⁸ In a study where a physiotherapist evaluated people with acute soft tissue injuries of the knee in the emergency room, 15 of the 17 patients in which MRI was ordered had significant ligamentous or meniscal injuries.¹⁹ This rate was significantly higher than the historical rate of accuracy of 45%.

Current Practice Regarding Sound Waves for Diagnostic Ultrasound:

Physiotherapists in Ontario with post-graduate level competencies working in musculoskeletal areas, mainly where they see patients in a post-operative setting following total hip or knee replacement, have been delegated the authority to order diagnostic ultrasound when a deep vein thrombosis (or blood clot) is suspected. Additionally, therapists with post-graduate training working in the area of incontinence have identified that the ability to order transvaginal and transrectal ultrasound would eliminate the need for patients to return to the referring physician in order to be referred on for the test, thereby reducing delays in treatment.

Education

Entry to practice physiotherapy education includes an introduction to MRI indications, contraindications and interpretation as well as theoretical knowledge of what information is provided by diagnostic ultrasound and circumstances in which it might provide diagnostic information in soft tissue conditions (see Appendix B). However, consultation clearly indicated that post-graduate training was required to achieve sufficient knowledge to have competency in ordering MRI or diagnostic ultrasound.

Current formalized post-graduate training is available within the context of institutionally-based training programs such as that at the Ottawa Hospital, as a component of special courses such as the Advanced Clinician Practitioner in Arthritis Care (ACPAC) Program based out of St. Michael's Hospital and the Hospital for Sick Children, Toronto (see Appendix C).²⁰ Post-graduate education is also available within the Rehabilitation Science Masters Program at McMaster University (see Appendix C).²¹ All of these courses include theoretical material combined with clinical practical experience.

Competency Evaluation:

Competency evaluation occurs in the contexts described above in which physiotherapists are able to have their competency evaluated prior to implementation in the practice setting. Physiotherapists are performing these acts now under delegation without incident. Further, there is evidence that the utilization of the ordering and the accuracy of the request are well within the expected performance of medical practitioners in the same circumstance.

In summary physiotherapists entry to practice education provides a strong underpinning on which

15 Hockin, J., and G. Bannister 1994, *Physiotherapy*

16 Jibuike, O. O., B. P. Taylor, S. Maulvi, et al 2003. *Emergency Medicine Journal*

17 Moore, J. H., D. L. Goss, et al 2005. *Journal of Orthopaedic & Sports Physical Therapy*

18 Moore, J. H., D. L. Goss, et al 2005. *ibid*

19 Jibuike, O. O., et al 2003. *ibid*

20 Landon K, R. Shupak, L. Sunstrum-Mann, et al 2008, *Health Care Quarterly*

21 McMaster University Rehabilitation Science program http://www.fhs.mcmaster.ca/grad/rehab/course_descriptions.htm

post graduate training builds to permit demonstrated competence in the area of ordering MRI and diagnostic ultrasound.

2. Evidence for other proposed revisions to statutory provisions

The current submission proposes revisions to statutory provisions, of which two pertain to the ordering of diagnostic tests: the Healing Arts Radiation Protection Act and the Laboratory and Specimen Collection Centre Licensing Act. The proposed revisions to the Healing Arts Radiation Protection Act would enable physiotherapists to order x-ray imaging (plain radiographs, computerized tomography scans and scans for bone density). The proposed revisions to the Laboratory and Specimen Collection Centre Licensing Act would enable physiotherapists to order laboratory tests. Currently, physiotherapists in Ontario who are involved in these actions do so under medical directives.

Table A2 provides an overview of support within entry to practice curricula and post-graduate education for the proposed revisions. See Appendix B for tabulated information from Ontario Academic Programs of the entry to practice curricula related to the proposed revisions. See Appendix C for information about post-graduate education programs.

Table A2: Summary of Educational Support for the Proposed Revisions to the Healing Arts Radiation Protection Act and the Laboratory and Specimen Collection Centre Licensing Act

		Education	
		Entry- to- practice	Post-graduate
Healing Arts Radiation Protection Act			
1	Section 6: addition of physiotherapists to the list of persons who are permitted to order x-rays	partially	yes
2	Sections 6: additional clause specifying the areas of the body upon which physiotherapists can order x-rays. These include: chest, the ribs, the spine (including the cervical, thoracic and lumbar spine), the shoulder, the elbow, the wrist, the hand, the pelvis, the hip, the knee, the leg, the ankle or the foot.	partially	yes
Laboratory and Specimen Collection Centre Licensing Act			
1	Changes to Section 9 of Regulation 682 to permit owner/operators of laboratories to examine specimens that were taken at the request of a physiotherapist.	Not applicable	Not applicable
2	Changes to the appendices of Regulation 682 develop a new appendix (Appendix D) that will define the laboratory tests that physiotherapists can order. This list of proposed tests includes: Complete blood count (CBC) C-reactive protein (CRP) Erythrocyte sedimentation rate (ESR) Rheumatoid factor (RF) Antinuclear antibodies (ANA) Glucose (quantitative) Transthyretin (TTR) (prealbumin)	partially	yes

Proposed revisions to the Healing Arts Radiation Protection Act

1. Section 6

Addition of physiotherapists to the list of persons who are permitted to order x-rays

Current Practice:

As indicated in the submission, changes will be required to the HARP Act to enable physiotherapists to order x-ray imaging. Currently under medical directives, physiotherapists with post-graduation education are ordering x-rays in settings where patients who have been referred for total hip or knee replacement (e.g. in Ottawa, Hamilton, Kingston and the Greater Toronto Area and other areas) require evaluation and follow up. Therapists working in geriatric and complex continuing care settings or in private practice in Ontario also have indicated that the ability to order x-rays would facilitate care for patients particularly when a fracture is suspected.

Physiotherapists order x-rays in other Canadian jurisdictions such as the Annapolis Valley in Nova Scotia and more recently in Alberta, where physiotherapists have been ordering plain film x-rays since 2004. The process began when the medical society gave this authority to Nurse Practitioners. Chiropractors and physiotherapists were granted this authorization as well. The authorization was initially a one year trial but has continued as there was no abuse of the privilege and a survey of physiotherapists in both the public hospital and private sectors indicated that the ability to order x-rays was an asset. The process has been structured such that the radiologist's report is sent to both the physiotherapist and the patient's physician. In cases where there are concerns regarding the radiological findings the patient is sent back to the physician and the therapist does not discuss the results. In Alberta, therapists work in settings similar those described for hip and knee replacement in Ontario.

Physiotherapists in Britain and the US also order x-rays.^{22,23,24,25} In these international locations, therapists are working in a variety of settings including independent practice, the emergency room, arthritis, spine, orthopaedic and primary care clinics.

Education:

Education at entry-level physiotherapy training includes anatomy, the indications and contraindications for ordering x-rays and their interpretation (see Appendix B). While all physiotherapists consulted agreed that the additional post-graduate training was required for enhanced knowledge, all also recognized that the entry-level education positioned physiotherapists well for post-graduate training.

Similar to the discussion above related to ordering forms of energy such as MRI and diagnostic ultrasound, there is formalized post-graduate training including both theoretical and practical components (see Appendix C).²⁶

Competency Evaluation:

Evaluation of basic knowledge and skills related to x-rays currently occurs within the entry to practice academic programs. Graduates of those programs must undertake the national Physiotherapy Competency Examination in order to become registered physiotherapists in Ontario. The Exam

22 Hourigan, P. G. and C. R. Weatherly 1994, *Journal of the Royal Society of Medicine*

23 Jibuike, O. O., B. P. Taylor, S. Maulvi, et al 2003. *Emergency Medicine Journal*

24 Moore, J. H., D. L. Goss, et al 2005. *Journal of Orthopaedic & Sports Physical Therapy*

25 Ball, S. T., K. Walton and S. Hawes 2007, *Emergency Medicine Journal*

26 Landon K, R. Shupak, L. Sunstrum-Mann, et al 2008, *Health Care Quarterly*

Blueprint²⁷ lists the following relevant examination element:

- assessment and evaluation includes “Obtain the following client information and interpret implications for intervention: [...] Special tests and diagnostic procedures (e.g. angiography, stress test, arthrogram, pulmonary function tests, roentgenogram, CT, MRI reports, sonograms, and electrocardiogram)”

Competency acquired within post-graduate education occurs within the context of those programs (see Appendix C).

In summary, given appropriate training and competencies authorization of this act to physiotherapists would improve access and timely care for patients.

2. Section 6

Additional clause specifying the areas of the body upon which physiotherapists can order x-rays. These include: chest, the ribs, the spine (including the cervical, thoracic and lumbar spine), the shoulder, the elbow, the wrist, the hand, the pelvis, the hip, the knee, the leg, the ankle or the foot.

Current Practice:

As noted in the first requested change to Section 6, physiotherapists in Ontario and Canada currently only order x-rays for musculoskeletal conditions. As such, the body parts specified upon x-rays can be ordered include the chest, spine, extremities and peripheral joints. As noted in the summary of the entry level curriculum (see Appendix B), physiotherapists also have competencies related to the indications for chest x-rays related to pulmonary conditions. Therefore, chest x-rays might be ordered if there are concerns about bony pathology or injury to the rib cage or pulmonary pathology.

Education and Competency Evaluation:

The entry level education and post-graduate education related to x-rays is described in the first point related to adding physiotherapists to the list of those who can order x-rays. Appendices B and C also reflect specific education and competency evaluation related to the specified anatomical sites.

Proposed revisions to the Laboratory and Specimen Collection Centre Licensing Act

As indicated in the submission, changes will be required to this act to enable physiotherapists to order tests governed by this Act and for owners/operators of laboratories to examine specimens that were taken at the request of a physiotherapist.

Changes to Section 9 of Regulation 682 to permit owner/operators of laboratories to examine specimens that were taken at the request of a physiotherapist.

Changes to the appendices of Regulation 682 to develop a new appendix that will define the laboratory tests that physiotherapists can order. This list of proposed tests includes:

- Complete blood count (CBC)
- C-reactive protein (CRP)
- Erythrocyte sedimentation rate (ESR)
- Rheumatoid factor (RF)
- Antinuclear antibodies (ANA)
- Glucose (quantitative)
- Transthyretin (TTR) (prealbumin)

²⁷ Canadian Alliance of Physiotherapy Regulators 2005, Physiotherapy Competency Examination Blueprint

Current Practice:

Physiotherapists in Ontario with post-graduate training currently order tests by delegation in orthopaedic triage clinics where patients who have been referred for total hip or knee replacement are evaluated and followed post surgery (e.g. in Ottawa, Hamilton, Kingston and the Greater Toronto Area) and in rheumatology clinics where they evaluate and follow patients with different types of arthritis. Delegation also occurs for therapists in British Columbia (see Appendix E) and consultant therapists in the UK have competencies that permit them to order laboratory tests.

Physiotherapists are authorized to order CBC, full white blood cell differential and inflammatory markers (erythrocyte sedimentation rate and C-reactive protein) in most centres. CBC provides an indication of such conditions as anaemia. Severe anaemia can result in physical dysfunction due to overwhelming fatigue. In such case evaluation by a physician for further evaluation and possible treatment would be required. The inflammatory markers are indicative of such conditions as inflammatory arthritis or autoimmune disease which require medical management and referral to a physician. Additionally, the white blood cell differential may indicate an inflammatory process. Swollen joints (particularly more than one), symptoms of pain, prolonged morning stiffness would be indications for evaluation of inflammatory markers. While most physiotherapists are authorized to evaluate a limited number of markers, additional factors such as rheumatoid factor and ANA which may indicate organ involvement and an autoimmune disease have been included in this request for completeness. The authorization to order these tests in the community where physiotherapists are accessed without physician referral is critical to ensure that patients who have conditions that require medical management get appropriate referral for care rapidly. Additionally, in settings where physiotherapists are working with patients with inflammatory arthritis and are seeing patients in follow-up who are receiving disease modifying arthritic agents (DMARDs) or biologics, authorization includes additional tests including haemoglobin, haematocrit, liver and kidney function and muscle markers as indicated in the submission.

For physiotherapists working in wound care, the authorization to order a CBC to obtain and a white blood cell differential and haemoglobin and haematocrit, as well as pre-albumin allows them to evaluate a patient for possible infection that may need medical treatment and for nutritional status (particularly pre-albumin). Nutritional status provides an indication of the individual's ability to heal.

Education:

Current entry-level practice provides theory regarding indications and interpretation for some laboratory tests (see Appendix B). For example, inflammatory markers are included in curricular content related to inflammatory arthritis. However, consultation indicated that the ordering of tests under this act requires post-graduate training.

Competency Evaluation:

Current post-graduate educational programs include theoretical and practical training and competency evaluation (see Appendix C).²⁸

In summary, ordering of tests under this act can and is being done by physiotherapists who have demonstrated competencies. CBC, differential and inflammatory markers are critical when inflammatory or autoimmune diseases are suspected. Additionally, the ability to order a broader set of tests as described above would enable physiotherapists working in inflammatory arthritis or wound care to facilitate system efficiencies.

²⁸ Landon K, R. Shupak, L. Sunstrum-Mann, et al 2008, *Health Care Quarterly*

3. Evidence for potential future revisions to authorized controlled acts and statutory provisions

There is recognition that health care is evolving rapidly in the face of increasing needs to provide care in a era of increasing prevalence of chronic disease and limited health human resources. Models of care evolving at both the macro and micro level are utilizing innovative approaches to collaborate and capitalize on areas of competence both individual professional and interprofessional. In our research, emerging areas of physiotherapist competencies were identified and are discussed here with respect to their current status. Following their evolution and use in the system to facilitate efficient and effective patient care outcomes will be important to ensure ongoing responsiveness of the Physiotherapy Act and other statutory provisions to the health care environment.

a. Setting or casting a fracture of a bone or a dislocation of a joint when: the fracture or dislocations of a bone or joint in an extremity, and the fracture or dislocations is set without the use of surgical technique.

Current Practice:

Physiotherapists in Ontario do not currently set patient's fractures. However, given their extensive training in musculoskeletal anatomy and physiology they have the background that positions them to set fractures and dislocations with little additional training. Internationally this trend is growing. In jurisdictions such as the UK, physiotherapists currently have this authority. A study of a physiotherapists working in the emergency room indicated that there was no statistically significant difference between the diagnosis, x-ray interpretation and management between the therapists and physician.²⁹ The study did acknowledge that these treatment protocols facilitated better management.

In addition to the emergency room setting described above, consultation identified a need for physiotherapists working in geriatric centres and complex continuing care to be able to set or cast fractures. In all of these settings, system efficiencies can realized by physiotherapists reducing the burden on busy emergency rooms. Additionally, patients in geriatric centres and complex continuing care can be managed without the stress of travel to and from and the wait at the emergency room.

Education:

The current entry-to- practice curricula for physiotherapists provides solid underpinnings in anatomy, physiology and healing principles of bone essential for this area of practice (see Appendix B).

Plain x-rays are a requisite for diagnosing a fracture and reviewing the alignment post fracture reduction. Existing content within the education program has been discussed under requested changes to the Healing Arts Radiation Protection Act and it was acknowledged by all during consultation that additional training would be required at a post-graduate level to develop skills in identification of fracture, type of fracture, management algorithms, and technical skill acquisition for reducing the fracture. Currently, we are unaware of any training programs related to fracture setting accessible by physiotherapists in Canada.

Competency Evaluation:

Knowledge of fractures, dislocations and subluxations is evaluated in entry to practice programs. In addition, the Physiotherapy Competency Examination blueprint lists "fractures, dislocations and subluxations" in the sample list of areas of practice evaluated.³⁰

²⁹ Ball, S. T., K. Walton and S. Hawes 2007, *Emergency Medicine Journal*

³⁰ Canadian Alliance of Physiotherapy Regulators 2005, Physiotherapy Competency Examination Blueprint

In regard to the proposed future controlled act itself, mechanisms for competency evaluation would also need to be developed as part of the post-graduate training.

In summary, setting fractures may be an appropriate controlled act to authorize to physiotherapists in Ontario in the future.

b. Applying or ordering the application of electricity for electromyography and nerve conduction studies

Current Practice:

Physiotherapists are restricted from inserting needles below the dermis and are unable to order or apply electricity for electromyography and nerve conduction studies. No physiotherapists consulted were aware of anyone ordering or performing these acts in a clinical setting in Ontario or Canada. However, physiotherapists working the US army have the authority to order electromyography and nerve conduction studies.^{31,32}

The authority to order and perform such studies would be beneficial in primary care and upper extremity orthopaedic settings in order to expedite care for patients. Currently, signs and symptoms of impaired nerve conduction may be found on assessment but a physiotherapist must have a patient return to their referring physician with the suggestion that such studies be done. The physician, if in agreement, then refers the patient to a third individual who conducts the study. Impaired nerve function can result in muscle weakness and muscle strengthening strategies will differ in the face of nerve impairment as compared to muscle dysfunction. The ability to distinguish these types of muscle weakness would facilitate choosing the physiotherapy intervention or identifying if a referral to another health professional is warranted.

Education:

Current curricular content at the entry-level includes high level principles about motor and sensory nerve function. Additionally, diseases that affect peripheral nerves, the signs and symptoms of impaired nerve function and diagnostic testing are presented with principles of nerve recovery. However, all therapists and academics consulted agreed that post-graduate training was required for all aspects of theory and acquisition of practical skills. No one was aware of such post-graduate training accessible to physiotherapists in Canada.

Competency Evaluation:

As with fracture setting above, competency evaluation mechanisms would need to be established in conjunction with the post-graduate training.

In summary, applying and ordering electricity may be an appropriate authorized act for physiotherapists in Ontario in the future. As with setting fractures, education and competency evaluation mechanisms currently do not exist such that the environment should continue to be evaluated related to need and potential development of skills.

c. Medication management after initial order

Current Practice:

Medication management after the initial order has been made is an emerging area of practice. In Alberta, pharmacists have been granted this authority and physiotherapists have established a

31 Moore, J. H., D. L. Goss, et al 2005. *Journal of Orthopaedic & Sports Physical Therapy*

32 Aiken, A. B. and M. A. McColl 2008, *Journal of Interprofessional Care*

'collaborative agreement' with pharmacists to facilitate medication management for their patients. No physiotherapists in Ontario currently manage medication.

Physiotherapists in the US army are allowed to pursue education in pharmacology for purposes of prescribing as part of post-graduate training (Benson 1995). To date, there have been no legal suits brought against therapists. In the UK, consultant physiotherapists have the authority to order cortisone for the purposes of joint injection (Atkin 2003).

Physiotherapists provide care for people with acute injuries, post surgery, and with chronic diseases. The authority to manage medications would permit medication to be tailored to patient's symptoms during the course of their rehabilitation and would prevent the need for physicians to be involved in the provision of repeat prescriptions for all patients resulting in system efficiencies.

Education and Competency Evaluation:

Within the current entry to practice curricula, medications related to specific diseases are reviewed (see Appendix B). At the post-graduate level, some courses related to specific diseases among those listed in Appendix C provide more detailed content. Evaluation occurs based on the material presented; however, there was consensus by those consulted that additional training would be required regarding the indications, dosage, contraindications, and side-effects for various medications that physiotherapists might manage. This education and competency evaluation would occur at the post-graduate level.

Physiotherapy Scope of Practice Review

Appendix B

Overview of entry to practice education curricular elements from Ontario academic physiotherapy programs related to the proposed revisions to controlled acts authorized to physiotherapists and to other statutory provisions.

The information presented in the following tables was compiled from responses provided from Ontario universities that have entry to practice programs in physiotherapy / physical therapy. It is important to note that all programs undergo accreditation by the same Canadian accreditation standards, all programs participate in the ongoing revisions to the Canadian curriculum guidelines and all programs' graduates must undertake the national Physiotherapy Competency Examination in order to become registered physiotherapists in Ontario. Therefore, differences among programs are largely in instructional strategies and curricular flow. Any differences in curricular content across programs are minor and are expected to remain minor.

At the time that academic programs' responses were sought, the developers of this submission were considering proposing a greater number of revisions to controlled acts and related statutory provisions than appear as the exact changes currently proposed in the response to Question 12 of the main document.

Table B1 presents the compilation of the academic programs' responses regarding the currently proposed revisions. Table B2 presents the compilation of the academic programs' responses regarding potential future revisions.

Table B1: Overview of entry to practice education curricular elements compiled from Ontario academic physiotherapy programs related to the proposed revisions to controlled acts authorized to physiotherapists and to other statutory provisions

Additional Controlled Acts Proposed to be Authorized to Physiotherapists in Ontario	Is the controlled act and corresponding competencies supported in the curriculum?		Evidence of Evaluation
	Yes/ Partially/ No	Description of Curricular Content	
Communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person's symptoms.	yes	Throughout the curriculum, students are taught to synthesize assessment findings to arrive at an analysis [i.e., a "physiotherapy diagnosis"] and to seek informed consent before proceeding to provide intervention. Informed consent necessitates the communication of the assessment findings.	Written and clinical examinations throughout the curriculum in multiple courses Clinical Performance Instrument (CPI) used to evaluate students in clinical placements
Treating a wound including by cleansing, soaking, irrigating, probing, debriding, packing or dressing the wound.	partially	Students are taught basic science anatomy and physiology of dermis and mucous membranes, pathological conditions arising in wounds, burns, etc. There is limited ability to practice clinical skills in the academic context.	Evaluated via written exam in all students. A few students will learn and have their clinical skills evaluated in clinical placement contexts.
Administering by inhalation:			
i. oxygen, or	yes	Students learn physiology, including exercise physiology, regarding the use of oxygen, maintaining oxygen saturation, technology for measuring oxygen saturation and the interpretation of measured values. Students learn about multiple conditions in which supplemental oxygen is used and in which oxygen saturation is carefully monitored: e.g., exercise in post-operative patients or in patients with chronic obstructive pulmonary disease, during suctioning of patients in intensive care unit. Students learn current national practice guidelines, including evidence for hyperoxygenation with suctioning.	Evaluated via written examinations and practical clinical skills examinations in all students.

Additional Controlled Acts Proposed to be Authorized to Physiotherapists in Ontario		Is the controlled act and corresponding competencies supported in the curriculum?	
		Yes/ Partially/ No	Evidence of Evaluation
ii. a drug or substance that has been ordered by a person who is authorized to do so by the Chiropractic Act, 1991; the Dentistry Act, 1991; the Medicine Act, 1991; the Nursing Act, 1991; or, the Midwifery Act, 1991.		partially	Pharmacology and indications for inhaled drugs that affect respiratory status and for which timing of dosage is relevant to excretion and secretion clearance as a component of physiotherapy assessment and intervention
Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment or treatment.		partially	Students learn anatomy of pelvic floor musculature relative to external genitalia and related structures. Students learn about numerous conditions in which bladder control may be altered and/or pelvic pain may be present: e.g., spinal cord injury, post-partum. Clinical skills described but not taught to all students.
Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder, the application of electromagnetism for magnetic resonance imaging.		partially	In courses about musculoskeletal, cardiorespiratory and neurological conditions, students are taught to understand the images and information that can be obtained from these tests: specifically, for example, MRI related to numerous types of MSK and neuro trauma and disease. Students are also taught about the circumstances under which these imaging tests may be ordered or not.
Ordering, for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder, the application of sound waves for diagnostic ultrasound.		partially	In courses about musculoskeletal, cardiorespiratory and neurological conditions, students are taught to understand the images and information that can be obtained from these tests: specifically, for example, diagnostic ultrasound related to soft tissue injury or vascular disease. Students are also taught about the circumstances under which these imaging tests may be ordered or not.

Proposed revisions to other statutory provisions		Are the corresponding competencies supported in the curriculum?		Evidence of Evaluation
		Yes/Partially/ No	Description of Curricular Content Basic Science e.g. Physiology etc and/or Clinical Science e.g. skill acquisition etc	
Healing Arts Radiation Protection Act (HARP):				
1.	Section 6: addition of physiotherapists to the list of persons who are permitted to order x-rays	partially	In courses about musculoskeletal and cardiorespiratory conditions, students are taught to understand the images and information that can be obtained from these tests: specifically, for example, plain x-ray related to fracture, injured/diseased joints, chest status such as pneumonia, atelectasis. Students are also taught about the circumstances under which these imaging tests may be ordered or not.	Written examination in courses; some limited clinical skill evaluation of interpreting chest and musculoskeletal x-rays.
2.	Sections 6: additional clause specifying the areas of the body upon which physiotherapists can order x-rays. These include: chest, the ribs, the spine (including the cervical, thoracic and lumbar spine), the shoulder, the elbow, the wrist, the hand, the pelvis, the hip, the knee, the leg, the ankle or the foot.	partially	See immediately above	See immediately above
Laboratory and Specimen Collection Centre Licensing Act Changes:				
1.	Changes to Section 9 of Regulation 682 to permit owner/operators of laboratories to examine specimens that were taken at the request of a physiotherapist.	Not applicable	Not applicable	Not applicable
2.	Changes to the appendices of Regulation 682 develop a new appendix that will define the laboratory tests that physiotherapists can order. This list of proposed tests includes: Complete blood count (CBC) C-reactive protein (CRP) Erythrocyte sedimentation rate (ESR) Rheumatoid factor (RF) Antinuclear antibodies (ANA) Glucose (quantitative) Transthyretin (TTR) (prealbumin)	partially	In courses about musculoskeletal, cardiorespiratory and neurological conditions, students are taught to understand the commonly used laboratory tests and information that can be obtained from these tests: specifically, for example, the implications of abnormal test results for haemoglobin or white blood cell which are part of the CBC counts in relation to fatigue and infection respectively; the implications of CRP, ESR, ANA in relation to inflammatory and autoimmune disease; and, prealbumin as a measure of nutritional status and wound healing potential.	Written examination in courses; some limited clinical skill evaluation of interpreting chest and musculoskeletal x-rays

Table B2: Overview of entry-to-practice education curricular elements compiled from Ontario academic physiotherapy programs related to emerging areas of practice and possible future revisions

<u>Emerging areas of practice</u>		Is the authorized act and corresponding competencies supported in the curriculum?	
	Yes/ Partial/ No	Description of Curricular Content Basic Science e.g. Physiology etc and/or Clinical Science e.g. skill acquisition etc	Evidence of Evaluation
Setting or casting a fracture of a bone or a dislocation of a joint when: the fracture or dislocation is of a bone or joint in an extremity, and the fracture or dislocation is set without the use of surgical technique.	partially	Students learn musculoskeletal system anatomy (prerequisite course to program entry) and about injuries including fractures & dislocations: mechanism of injury, healing, management. Setting or casting a fracture of a bone or a dislocation of a joint is not explicitly taught.	Written examination in those courses
Prescribing drugs that may be designated in regulations / medication management.	partially	Pharmacology of commonly used medications in MSK (esp. rheumatological) conditions, neurological conditions and cardiorespiratory conditions. For commonly used medications, students are taught about indications and mechanism of action, as well as how to identify common side effect profile. For commonly used medications that have immediate effects in relation to physiotherapy interventions (e.g., drugs to reduce pain, dyspnea, etc), students are taught the importance of timing medication dose with respect to physiotherapy intervention. Detailed pharmacology and pharmaceutical management principles are not taught.	Written examination in those courses

Physiotherapy Scope of Practice Review

Appendix C

Post-graduate education opportunities currently available in Ontario for physiotherapists to develop and be evaluated on post- entry to practice competencies related to the proposals for revisions to controlled acts authorized to physiotherapists and to other statutory provisions.

University-based programs related to wound care

University of Toronto:

Master of Science Community Health (MScCH) University of Toronto Dalla Lana School of Public Health

The MScCH program is intended for and limited to established health professionals who wish to enhance their professional knowledge and skills, while being able to remain employed/in practice. [...] Health practitioners who graduate from the program will have enhanced their professional leadership and teaching skills with a comprehensive understanding of public health, and their specific specialty areas. The program emphasizes critical, analytic, interpretive and scholarly skills. Furthermore, this program will help develop professional models for improved interprofessional team practice and education spanning clinical, community and public health.

Four fields are offered [of which one is Wound Prevention and Care]

http://www.phs.utoronto.ca/MScCH_WPC.asp

University of Western Ontario:

Masters of Clinical Science in Wound Healing University of Western Ontario School of Physical Therapy

The Masters of Clinical Science in Wound Healing is designed to provide an interprofessional educational experience at the graduate studies level that will focus on the development of specialized clinical skills and research methodology needed to assess and treat people with chronic wounds. It will allow participants to develop and practice knowledge, skills, and behaviours needed to support and foster best practices in wound care, appreciate roles of interdisciplinary wound care team members, and obtain research skills that will facilitate critical appraisal of research literature and active participation in wound care research. It is hoped that this interprofessional MClSc program in Wound Healing will help establish wound care as a distinct and legitimate area of specialized practice and build capacity of wound care researchers in Canada.

http://www.uwo.ca/fhs/pt/prospective/mclsc/wound_healing.html

University-based programs related to advanced practice physiotherapy in musculoskeletal disorders, including competency teaching and evaluation relevant to ordering diagnostic tests (magnetic imaging, ultrasound, x-ray imaging), laboratory tests and medication management

McMaster University:

**Master's program in Rehabilitation Science (thesis and course-based)
McMaster University School of Rehabilitation Science**

This course based Master's program in Rehabilitation Science has been designed for occupational therapists, physical therapists and other health professionals with a baccalaureate degree (4-year degree or equivalent), who have already established their eligibility to practice in their discipline but want advanced knowledge and an opportunity to enhance their qualifications.

http://www.fhs.mcmaster.ca/grad/rehab/course_descriptions.htm

University of Western Ontario:

**Masters of Clinical Science in Manipulative Therapy
University of Western Ontario School of Physical Therapy**

The Masters of Clinical Science in Manipulative Therapy is designed to prepare physiotherapists to be competent in the assessment and treatment of musculoskeletal dysfunction to enable effective management of the complexity of clinical presentations. It represents a partnership between the National Orthopaedic Division (NOD) of the Canadian Physiotherapy Association (CPA) and the School of Physical Therapy. Successful graduates of this program will obtain the equivalent of Levels 3, 4, and 5 of the NOD courses and receive the designation of FCAMT. In addition, graduates will obtain the research competencies necessary for CPA specialization.

http://www.uwo.ca/fhs/pt/prospective/mclsc/manipulative_therapy.html

Hospital-based programs in advanced practice physiotherapy in musculoskeletal disorders

The Sunnybrook Holland Orthopaedic & Arthritic Centre has developed an Advanced Practice Physiotherapy Hip and Knee Training and Development Program with a toolkit for other sites implementing similar initiatives.¹

Contact Information:

Deborah Kennedy MSc BScPT
Manager, Hip and Knee Program Development
Sunnybrook Holland Orthopaedic & Arthritic Centre
43 Wellesley St East, Rm 250
Toronto, Ontario M4Y 1H1
416-967-8560

St. Michael's Hospital / Hospital for Sick Children Advanced Clinician Practitioner in Arthritis Care (ACPAC) Program

The ACPAC (Advanced Clinician Practitioner in Arthritis Care) Program is an innovative, unique academic and clinical-education training program in advanced musculoskeletal/arthritis care currently offered to experienced physical and occupational therapists. The program is hosted by St. Michael's Hospital, in collaboration with The Hospital for Sick Children, and the University Health Network.

The ACPAC program was developed in response to the well-recognized need for an interdisciplinary approach to better manage patients presenting with osteoarthritis (OA) as well as in the early detection of rheumatoid arthritis (RA) by improving access to (shortened wait times) and efficiency of care.

The ACPAC program provides the mechanism for training advanced practitioners to assume vital roles of triage, education and in select cases, management of patients with osteoarthritis and inflammatory arthritis.

<http://www.stmichaelshospital.com/programs/mobility/acpac.php>

Contact Information:

Katie Lundon, k.lundon@cogeco.ca

The Ottawa Hospital Program to prepare advanced practice physiotherapists to work under medical directive in "Hip and Knee Replacement, Orthopedics"

The Advanced Practice Physiotherapist (APP) will be able to order specific lab tests [as outlined in another document, specifically Peripheral white blood-cell count, C-reactive protein level, Erythrocyte sedimentation rate, Hemoglobin, Hematocrit].

The APP will be able to make a general interpretation of a patient's X-Ray to determine normal versus abnormal findings to communicate any abnormal finding back to the orthopedic surgeon. The APP will be able to write a consult for outpatient physiotherapy on behalf of the surgeon. The APP will be able to assess the surgical wound of patients and engage in some specific

¹ See also Robarts, Kennedy, et al 2008, *Health Care Quarterly*

interventions such as removal of staples and trimming of sutures.

The APP will be able to assess the need for and the indications for an intra-articular steroid. After the assessment and consultation with the orthopaedic surgeon, the APP can deliver the intra-articular steroid.

Contact Information:

Frédéric Beauchemin, Chief of Physiotherapy

The Ottawa Hospital – Civic Campus

CPC - Room 307

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Ottawa ON K1Y 4E9

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Fax: 613-761-5446

Email: fbeauchemin@ottawahospital.on.ca

Physiotherapy Scope of Practice Review

Appendix D

Relevant documents from the College of Physiotherapists of Ontario

Appendix D

1. Standard for Professional Practice – Performing Controlled Acts

http://www.collegept.org/college/content/pdf/en/reg_guide/3.%20STANDARDS%20FOR%20PRACTICE%20FOR%20PHYSIOTHERAPISTS/B.%20STANDARDS_PROFESSIONAL%20PRACTICE/Performing%20Controlled%20Act%20Standard.pdf

2. Guide to the Standard for Professional Practice – Performing Controlled Acts

http://www.collegept.org/college/content/pdf/en/reg_guide/3.%20STANDARDS%20FOR%20PRACTICE%20FOR%20PHYSIOTHERAPISTS/B.%20STANDARDS_PROFESSIONAL%20PRACTICE/Guide%20-%20Performing%20Controlled%20Acts%20-%20May%202008.pdf

3. College Quality Management Framework

http://www.collegept.org/college/content/pdf/en/reg_guide/3.%20STANDARDS%20FOR%20PRACTICE%20FOR%20PHYSIOTHERAPISTS/C.%20STANDARDS_PROFESSIONAL%20CONTINUING%20COMPETENCE/2_Framework%20document%20FINAL_Nov%202007.pdf

4. College Practice Assessment Process

http://www.collegept.org/college/content/pdf/en/reg_guide/3.%20STANDARDS%20FOR%20PRACTICE%20FOR%20PHYSIOTHERAPISTS/C.%20STANDARDS_PROFESSIONAL%20CONTINUING%20COMPETENCE/Practice%20Assessment%20brochure%20FINAL_dec%202007.pdf

5. Regulation 861/93 Professional Misconduct

http://www.collegept.org/college/content/pdf/en/reg_guide/2.%20LEGISLATION,%20REGULATIONS%20AND%20BY_LAWS/Professional_Misconduct_Regulation%202008.pdf

6. Proposed revised version of the College Professional Misconduct Regulation (See attached text)

7. College Annual Registration Renewal Form (see attached text)

ONTARIO REGULATION

made under the

PHYSIOTHERAPY ACT, 1991

PROFESSIONAL MISCONDUCT

1. The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

1. Failing to maintain the standards of practice of the profession.
2. Discontinuing professional services that are needed unless,
 - i. the patient requests the discontinuation,
 - ii. alternative services are arranged,
 - iii. the patient is given a reasonable opportunity to arrange alternative services,
 - iv. the member is unable to provide adequate physiotherapy services because there are insufficient resources available,
 - v. the patient has failed to make payment within a reasonable time for physiotherapy services received and all reasonable attempts on the part of the member to facilitate such payment have been unsuccessful,
 - vi. the member has reasonable grounds to believe that the patient may abuse the member, verbally, physically or sexually, or
 - vii. the patient's lack of cooperation or compliance with his or her treatment plan is such that, in the member's opinion, the services are not effective.
3. Contravening, by act or omission, a term, condition or limitation on the member's certificate of registration.
4. Practising the profession while the member's certificate of registration has been suspended.
5. Practising the profession while the member is in a conflict of interest.
6. Practising the profession while the member's ability to do so is impaired by any substance.
7. Performing a professional service for which consent is required by law without such consent.
8. Delegating a controlled act to another person unless that person has the knowledge, skills and judgement to perform the controlled act.
9. Performing a controlled act that was delegated to the member by another person unless the member has the knowledge, skills and judgement to perform the controlled act.
10. Abusing a patient.

11. Failing to fulfil an undertaking provided to the College.
12. Failing to comply with an order of a statutory committee of the College when the order is issued in accordance with the committee's authority under the Regulated Health Professions Act, 1991.
13. Failing to reply appropriately or within a reasonable time to a written inquiry from the College.
14. Contravening, by act or omission, the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts.
15. Contravening a federal, provincial or territorial law relevant to the member's suitability to practise.
16. Failing to make a mandatory report that is required by the Regulated Health Professions Act, 1991.
17. Failing to cooperate with an investigator from another College who gives proof of his or her appointment as an investigator under section 75 of the Health Professions Procedural Code or to provide the investigator with access to, or copies of a record, document or thing that may be reasonably required for the purpose of the investigation.
18. Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.
19. Conduct unbecoming a physiotherapist.
20. Using the title "specialist", unless the member holds a specialty designation recognized by the College.
21. Representing qualifications in a manner that is false, misleading or deceptive.
22. Assisting a person who is not a member to hold himself or herself out as a member registered to practise in Ontario.
23. Failing to report the name of a person to the College who is not registered to practice in Ontario, while having reasonable grounds to believe that the person is holding himself or herself out as a member registered to practise in Ontario.
24. Practising the profession using a name other than the member's name as entered on the register.
25. Advertising, unless the advertisement accurately and fairly presents verifiable information to assist a patient in choosing whether to engage the services of the member.
26. Failing to keep records in accordance with the standards of practice of the profession.
27. Falsifying a record.
28. Signing or issuing a document containing a statement that the member knows or ought to know contains a false or misleading statement.
29. Signing or issuing a certificate, report, or similar document without taking reasonable

- measures to ascertain the accuracy of its contents.
30. Failing, without reasonable cause, to provide a report or certificate relating to an examination or treatment performed by the member within a reasonable time to the patient or his or her authorized representative after a patient or his or her authorized representative has requested such a report or certificate.
 31. Giving information about a patient to a person other than the patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required or allowed by law.
 32. Submitting an account or charge for services that the member knows or ought to know is false or misleading.
 33. Failing to take reasonable steps to ensure that any accounts submitted in the member's name or billing number are fair and accurate.
 34. Charging a fee that is excessive in relation to the service performed.
 35. Charging a fee or accepting payment from a person for a service that has been paid for by another payer.
 36. Receiving, requesting or conferring a benefit, directly or indirectly, in relation to the referral of a patient.
 37. Charging a block fee, which is a set fee charged for a block of services, unless a block fee is required by a payment plan or,
 - i. the services covered by the fee are specified to the patient,
 - ii. the amount of the fee is specified to the patient, and
 - iii. the patient is given the choice of being able to purchase the services individually.
 38. Failing to itemize an account for professional services if requested to do so by the patient or the person or agency who is to pay, in whole or in part, for the services.
 39. Failing to advise a patient or his or her authorized representative of the fees charged by the member for professional services and any charges or penalties for late payment of the fees before performing the services.
 40. Continuing the treatment of a patient where it is no longer indicated, has ceased to be effective or is unnecessary.
 41. Failing to supervise, in accordance with the standards of practice of the profession.
 42. Failing to refer a patient to a regulated health professional when the member recognizes or ought to recognize an abnormality or condition which indicates such a referral.
- 2. Ontario Regulation 861/93 is revoked.**
 - 3. This Regulation comes into force on the day it is filed.**



College of Physiotherapists of Ontario

Annual Registration Form

Registration Number

2008

Please complete the entire Annual Registration Form and return it along with your fee to the College by **March 31, 2008**. For clarification about any portion of the form, please refer to the appropriate section of the Guide.

Section 1: General Information

Name

Address

Phone

Primary Email

Practice Hours

Please list below the number of practice hours completed January 1 to December 31, 2007. Please note: Only 30 professional activity hours may be claimed each year.

Worked Hours: 2007 _____ hours

Professional Activity Hours: 2007 _____ hours

Total Hours: 2007 _____ hours

Language Fluency

Please indicate the languages in which you are currently capable of providing physiotherapy services.

English

French

Other (Please list) _____

Professional Registration

If you are currently registered/licensed to practice as a physiotherapist in another jurisdiction or if you are registered to practice another health profession in any jurisdiction, please provide the details in this section.

Health Profession	Province/State/Country	Registration/License #

Professional Conduct

- a. Have you had a finding of professional misconduct, incompetency, or incapacity against you in another jurisdiction in the past year? Yes No
- b. Are you currently facing a proceeding for professional misconduct, incompetency, or incapacity against you in another jurisdiction? Yes No
- c. Have you been found guilty of a criminal offence or an offence related to the practice of physiotherapy in the past year? Yes No

If you answered Yes to the Professional Conduct questions, please provide details in the Additional Registration Information Section.



Section 2: Current Employment Information

2A: Primary Employment Site

Business Name

Address

Phone

Fax

Position/Title:

Employment Category

Employee

Self-Employed

Employment Status

Full-time Permanent

Part-time Permanent

Full-time Temporary

Part-time Temporary

Description of Primary Place of Employment (Choose one)

Arthritis Society

Industry

Professional/Health Association

Community Care Access Centre (CCAC)/Home Care Program

Long-Term Care Facility

Regional Evaluation Centre

Community Health Centre

Mental Health Facility

Rehabilitation Hospital/Facility

Complex Continuing Care

Pediatric Hospital/Facility

Retailer

Consulting Firm/Agency

Private Practice/Clinic

School Board

General Hospital

Designated Physiotherapy Clinic

University/Educational Institution

(Teaching or Non-teaching)

Yes No

Other (Please Specify) _____

Government/Other Official Agency

If no, select category of ownership.

(example – Armed Forces, Gov't Ministry)

A Physiotherapist

Another Regulated Health Professional

Home Visiting Agency

A non-regulated owner

Area(s) of Responsibility

Check those that apply as your primary area(s) of responsibility and indicate the percentage of your time spent in each area.

The percentage must total 100%.

Administration _____ %

Research _____ %

Other (Please Specify) _____ %

Consultation _____ %

Sales _____ %

Patient Care _____ %

Teaching _____ %

Total 100 %

Complete the remainder of this page only if you indicated that you perform patient care.

Category of Patients/Clients

Check those categories that apply as your primary responsibility.

All Ages

Pediatric

Adult

Geriatric

Area(s) of Practice

Check those areas of responsibility that apply and indicate the percentage of your clinical work time spent on each area of practice.

The percentage must total 100%.

Amputees _____ %

Orthopaedics _____ %

Sports Medicine _____ %

Cardiology _____ %

Palliative Care _____ %

Women's Health _____ %

Critical Care _____ %

Prevention/Health Promotion _____ %

Other (Please Specify) _____ %

General – All Areas _____ %

Rehabilitation _____ %

Mental Health _____ %

Respiriology _____ %

Total 100 %

Neurology _____ %

Rheumatology _____ %



Section 2: Current Employment Information

2B: Additional Employment Site

Business Name

Address

Phone

Fax

Position/Title:

Employment Category

Employee

Self-Employed

Employment Status

Full-time Permanent

Part-time Permanent

Full-time Temporary

Part-time Temporary

Description of Additional Place of Employment (Choose one)

Arthritis Society

Industry

Professional/Health Association

Community Care Access Centre (CCAC)/Home Care Program

Long-Term Care Facility

Regional Evaluation Centre

Community Health Centre

Mental Health Facility

Rehabilitation Hospital/Facility

Complex Continuing Care

Pediatric Hospital/Facility

Retailer

Consulting Firm/Agency

Private Practice/Clinic

School Board

General Hospital

Designated Physiotherapy Clinic

University/Educational Institution

(Teaching or Non-teaching)

Yes No

Other (Please Specify) _____

Government/Other Official Agency

If no, select category of ownership.

A Physiotherapist

(example – Armed Forces, Gov't Ministry)

Another Regulated Health Professional

Home Visiting Agency

A non-regulated owner

Area(s) of Responsibility

Check those that apply as your primary area(s) of responsibility and indicate the percentage of your time spent in each area.

The percentage must total 100%.

Administration _____ %

Research _____ %

Other (Please Specify) _____ %

Consultation _____ %

Sales _____ %

Patient Care _____ %

Teaching _____ %

Total 100%

Complete the remainder of this page only if you indicated that you perform patient care.

Category of Patients/Clients

Check those categories that apply as your primary responsibility.

All Ages

Pediatric

Adult

Geriatric

Area(s) of Practice

Check those areas of responsibility that apply and indicate the percentage of your clinical work time spent on each area of practice.

The percentage must total 100%.

Amputees _____ %

Orthopaedics _____ %

Sports Medicine _____ %

Cardiology _____ %

Palliative Care _____ %

Women's Health _____ %

Critical Care _____ %

Prevention/Health Promotion _____ %

Other (Please Specify) _____ %

General – All Areas _____ %

Rehabilitation _____ %

Mental Health _____ %

Respiriology _____ %

Total 100%

Neurology _____ %

Rheumatology _____ %



2C: Additional Employment Site		
Business Name		
Address		
Phone		
Fax		
Position/Title:		
Employment Category		
Employee <input type="checkbox"/>	Self-Employed <input type="checkbox"/>	
Employment Status		
Full-time Permanent <input type="checkbox"/>	Part-time Permanent <input type="checkbox"/>	
Full-time Temporary <input type="checkbox"/>	Part-time Temporary <input type="checkbox"/>	
Description of Additional Place of Employment (Choose one)		
<input type="checkbox"/> Arthritis Society	<input type="checkbox"/> Industry	<input type="checkbox"/> Professional/Health Association
<input type="checkbox"/> Community Care Access Centre (CCAC)/Home Care Program	<input type="checkbox"/> Long-Term Care Facility	<input type="checkbox"/> Regional Evaluation Centre
<input type="checkbox"/> Community Health Centre	<input type="checkbox"/> Mental Health Facility	<input type="checkbox"/> Rehabilitation Hospital/Facility
<input type="checkbox"/> Complex Continuing Care	<input type="checkbox"/> Pediatric Hospital/Facility	<input type="checkbox"/> Retailer
<input type="checkbox"/> Consulting Firm/Agency	<input type="checkbox"/> Private Practice/Clinic	<input type="checkbox"/> School Board
<input type="checkbox"/> General Hospital (Teaching or Non-teaching)	Designated Physiotherapy Clinic <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> University/Educational Institution
<input type="checkbox"/> Government/Other Official Agency (example – Armed Forces, Gov't Ministry)	If no, select category of ownership.	<input type="checkbox"/> Other (Please Specify) _____
<input type="checkbox"/> Home Visiting Agency	<input type="checkbox"/> A Physiotherapist	
	<input type="checkbox"/> Another Regulated Health Professional	
	<input type="checkbox"/> A non-regulated owner	
Area(s) of Responsibility		
<i>Check those that apply as your primary area(s) of responsibility and indicate the percentage of your time spent in each area. The percentage must total 100%.</i>		
<input type="checkbox"/> Administration _____ %	<input type="checkbox"/> Research _____ %	<input type="checkbox"/> Other (Please Specify) _____ %
<input type="checkbox"/> Consultation _____ %	<input type="checkbox"/> Sales _____ %	
<input type="checkbox"/> Patient Care _____ %	<input type="checkbox"/> Teaching _____ %	Total 100%
<i>Complete the remainder of this page only if you indicated that you perform patient care.</i>		
Category of Patients/Clients		
<i>Check those categories that apply as your primary responsibility.</i>		
<input type="checkbox"/> All Ages <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult <input type="checkbox"/> Geriatric		
Area(s) of Practice		
<i>Check those areas of responsibility that apply and indicate the percentage of your clinical work time spent on each area of practice. The percentage must total 100%.</i>		
<input type="checkbox"/> Amputees _____ %	<input type="checkbox"/> Orthopaedics _____ %	<input type="checkbox"/> Sports Medicine _____ %
<input type="checkbox"/> Cardiology _____ %	<input type="checkbox"/> Palliative Care _____ %	<input type="checkbox"/> Women's Health _____ %
<input type="checkbox"/> Critical Care _____ %	<input type="checkbox"/> Prevention/Health Promotion _____ %	<input type="checkbox"/> Other (Please Specify) _____ %
<input type="checkbox"/> General – All Areas _____ %	<input type="checkbox"/> Rehabilitation _____ %	
<input type="checkbox"/> Mental Health _____ %	<input type="checkbox"/> Respiriology _____ %	Total 100%
<input type="checkbox"/> Neurology _____ %	<input type="checkbox"/> Rheumatology _____ %	
<i>If you have more than three employment sites, please attach additional pages and provide all requested information.</i>		



Section 3: Practice Information

This section applies to all registrants. Please answer all questions below. Retired Status holders are not required to complete this section.

Authorized Acts

- 1) Do you perform the controlled act of tracheal suctioning? Yes No
- 2) Do you have training in spinal manipulation? Yes No
- 3) Do you perform the controlled act of spinal manipulation? Yes No
- 4) Do you have training in acupuncture/needling? (Acupuncture is a component of the controlled act of performing a procedure below the dermis that is currently exempted from the controlled act provisions.) Yes No
- 5) Do you perform acupuncture/needling? Yes No
- 6) Do you provide Patient Care? (**Direct Patient Care includes ANY COMPONENT OF** assessment, analysis of findings or provision of treatment to patients for whom you are directly responsible. This includes the assignment of any portion of care to support personnel.) (Note: This includes roles involving assessment, consultation or provision of treatment in schools, industry or fitness centres, occasional weekend or relief work or short term vacation coverage. Even an interaction with one patient per year counts as direct patient care.) Yes No

If you answered "No", proceed to Section 4 of this form.

Delegated Acts

Do you perform any of the following under medical directive or delegation?

- a) Do you adjust oxygen concentration? Yes No
- b) Do you put an instrument, hand or finger beyond the opening of the urethra, beyond the labia majora, beyond the anal verge (e.g., for incontinence training) Yes No
- c) Do you perform a procedure on tissue below the dermis (e.g., excluding acupuncture, but including the treatment of decubitus ulcers/wound debridement/ suture removal) Yes No
- d) Do you set or cast a fracture of a bone or a dislocation of a joint (e.g., setting a fracture through splinting or casting) Yes No
- e) Do you order the application of a form of energy (i.e., **ORDERING** X-rays, diagnostic ultrasound, EMG or nerve conduction studies; this **DOES NOT** apply to using ultrasound for treatment purposes) Yes No
- f) Do you prescribe, dispense, sell or compound a drug as defined in subsection 117(1) of the *Drug and Pharmacies Regulation Act* (e.g., instruct patients on altering dosage of prescription medication) Yes No



Section 4: Additional Registration Information/Comments

This section can be used to provide the College with any additional information or comments.

Section 5: Renewal Options/Payment

Option	Fee	✓Check Selection
Independent Practice Certificate for the period April 1, 2008 – March 31, 2009	\$600	
Academic Practice Certificate for the period April 1, 2008 – March 31, 2009	\$285	
Inactive Certificate for the period April 1, 2008 – March 31, 2009	\$140	
Resign Current Registration	No Fee	
Resign Current Registration and apply for Retired Status for the period April 1, 2008 – March 31, 2009	\$40	
Continue with Retired Status from April 1, 2008 – March 31, 2009	\$40	

Late Fees

All renewals post-marked after March 31, 2008 will be processed only if they include the applicable late fee.

Registration Category	Late Fee	✓Check if Included
Independent Practice Certificate	\$225	
Academic Practice Certificate	\$100	
Inactive Certificate	\$25	

Payment Options

Please indicate method of payment

- Visa
- Mastercard
- Cheque
- Money Order

If paying by credit card, please provide information below:

Card # _____

Expiry Date _____

Cardholder's Name _____

Cardholder's Signature _____

Authorized payment amount \$ _____



Section 6: Declaration

Please check off each declaration and sign the renewal form in the appropriate section below.

Independent Practice

- I hereby certify that all statements made on this form are complete and correct to the best of my knowledge and belief.
- I understand that I must notify the College in writing of any change to my address, phone number or employment information within thirty days of the change occurring.
- I understand that I must create a Professional Portfolio which includes details of my professional learning activities.
I understand that I must review the current Professional Issues Self Assessment (PISA) from the College..
- I understand the College may verify any information reported on this form.
- I meet the professional liability insurance guidelines as described in the College by-laws.
- I understand that providing false or misleading information will be viewed by the College as professional misconduct.

Signature _____

Date _____

Academic Practice

- I hereby certify that I will only practise physiotherapy in the department in which I hold the professional appointment and to the extent required by the teaching, research and service requirements of the appointment and that I will no longer be eligible for an academic practice certificate when my appointment is terminated.
- I declare that all statements made on this form are complete and correct to the best of my knowledge and belief.
- I understand that I must notify the College in writing of any change to my address, phone number or employment information within thirty days of the change occurring.
- I understand that I must create a Professional Portfolio which includes details of my professional learning activities.
I understand that I must review the current Professional Issues Self Assessment (PISA) from the College.
- I understand the College may verify any information reported on this form.
- I understand that providing false or misleading information will be viewed by the College as professional misconduct.

Signature _____

Date _____

Inactive/Retired Status

- I hereby certify that I will not practise as a Physiotherapist in Ontario during this renewal period and if I do decide to return to practice I will re-apply for appropriate registration with the College.
- I understand that my application will be subject to the registration requirements in place at the time of my application.
- I declare that all statements made on this form are complete and correct to the best of my knowledge and belief.
- I understand that I must notify the College in writing of any change to my address or phone number within thirty days of the change occurring (only applicable to Inactive registrants).
- I understand the College may verify any information reported on this form.
- I understand that providing false or misleading information will be viewed by the College as professional misconduct.

Signature _____

Date _____

Resignation

I wish to resign my registration with the College. I will no longer practise physiotherapy in Ontario and I understand that I am no longer eligible to use the protected title of physiotherapist in Ontario. I understand that if I wish to apply for registration with the College in the future, I will be subject to the registration requirements in place at the time of my application.

Signature _____

Date _____

Your privacy is protected

The personal information collected on this form is used by the College of Physiotherapists of Ontario for its regulatory purposes (e.g., the registration and identification of College registrants, the administration of statutes governing physiotherapists in Ontario and for the administration of the College) and to develop and provide aggregate or de-identified statistical information for human resource planning and demographic and research studies. It is collected under the authority of the Regulated Health Professions Act, the Health Professions Procedural Code, the Physiotherapy Act and the regulations and by-laws made under the authority of these statutes. The College does not sell this information nor does it provide the information to commercial entities in a format that facilitates mass marketing. To view the complete version of the College's Privacy Code, go to www.collegept.org.

Physiotherapy Scope of Practice Review

Appendix E

Canadian Jurisdictional Review

Introduction:

The purpose of the jurisdictional review was to identify available information about other jurisdictions related to the activities for which Ontario physiotherapists are currently seeking approval. A related aim was to determine, as possible, the level (entry or higher) at which such activities may be occurring. The major challenge in doing the scan was that in many if not most other jurisdictions, the available documentation (e.g., government legislation, Reports, By-Laws, Standards and other policy documentation of physiotherapy Colleges and Associations and other sites), contained less detail than what could be gathered directly via first hand discussions with Physiotherapy College Registrars (and in one case, a Canadian forces representative).

As well, it was determined during the review that a number of the physiotherapy acts did not cover the scope or activities at all, or in a way that was directly relevant to the enquiry. Similarly, umbrella health professional legislation either did not exist (as in the Maritime provinces) or was in the process of being refined or introduced (e.g. B.C. and Manitoba) and so fell short of providing relevant detail at this time. Alberta is the most similar to Ontario, with umbrella legislation and a list of restricted activities, and a physiotherapy act that authorizes physiotherapists to perform a number of these acts.

As a result, interviews with Registrars of provincial physiotherapy Colleges and the Canadian Forces provided the most up to date Canadian information, close to what is being explored in Ontario. The following information reviews whether the acts/activities in question were currently being practiced, and/or whether the provincial physiotherapy College had the authority to approve such activities (if they were not currently practiced).

Variance in Approaches in Other Canadian Jurisdictions

Not surprisingly, the information about approaches and authority for acts/activities varies according to jurisdiction. In the Maritime Provinces, for example, there is no central Act related to health professionals, and no set of restricted or controlled acts. In this context, the Colleges have authority to recognize and where deemed appropriate (for some activities), to require evidence of education/training, expertise, competence, and the possibility of requiring registration or placement on a roster (with annual follow-up information). When a response was “no,” “not allowed” or “not yet” from these jurisdictions, it tended to reflect that there was no demand, no location that could support it, or that the current relationship with and anticipated position of other health professionals (particularly medicine) might preclude physiotherapists from obtaining support for a given activity.

By contrast, Alberta has a central act for regulated health professionals similar to the RHPA in Ontario. It identifies a number of ‘restricted activities’ or ‘controlled acts’ that may not be performed unless there is explicit authorization to do so. British Columbia is currently refining and updating its central legislation for all health professionals, and Manitoba is in the process of introducing such legislation. In these cases, any acts or activities that are restricted (controlled acts, as articulated in Ontario) may be authorized for physiotherapists to perform, such as in Ontario, if permission is expressed in the provincial physiotherapy Act.

Three Illustrations of Flexibility in Supporting Legislation

Information regarding all Atlantic Provinces indicates great flexibility to respond to emerging practices as well as authority to recognize and regulate. For example, the Physiotherapy Act in Nova Scotia contains a phrase, “but is not limited to,” which provides the College with the flexibility to recognize

emerging skills and competency in different acts/activities.¹

Prince Edward Island has two sets of existing language that provide examples of dealing with emerging new practices within the scope of practice. A phrase in the Physiotherapy Act, "practised in a continuing way," provides the College with the flexibility to recognize emerging practices. In addition, there is authority to recognize any new or advanced competencies for additional oversight, through a specialist certificate or endorsement. The selected text from the Act illustrates these examples:

1(l): physiotherapy" means **physical therapy practised in a continuing way to remove, alleviate or prevent movement dysfunction or pain**, in a manner that requires the practitioner's independent exercise of professional knowledge, skill, judgment, and ethical conduct, and includes diagnostic assessment, design and conduct of treatment involving exercise, massage, hydrotherapy, heat, sonic, laser and electrical techniques, evaluation of progress, patient instruction, research and educational or preventative measures;"

The Physiotherapy Act also provides the College the authority to license/recognize/authorize specialist/ specialized activity as described in sections 1(e), and 7 as follows:

1(e)"license" means an authorization issued by the Council entitling license the holder to practise physiotherapy, and **includes a specialist certification or endorsement granted under section 7** or a special authorization granted under section 9;

7. The Council may, in accordance with qualifications, standards and Specialist conditions prescribed by regulation, grant a specialist certification or endorsement of an applicant's license to signify that person's entitlement to render acupuncture **or other amplified or specialized physiotherapy services**. 1988, c.50, s.8. ²

Alberta's legislative environment for physiotherapists is the most similar to Ontario. A central health professions Act defines 'restricted activities,' and a Physiotherapy Act states that physical therapists "provide restricted activities authorized by regulation." One difference is that the Physiotherapy Act provides for flexibility to recognize advances in entry to practice competencies over time, in terms of how restricted activities are listed as either "Basic authorized activities" or "Other authorized activities." Those restricted activities that are defined as 'Basic' are considered to be within entry to practice competency, while for 'Other' activities, the College requires additional evidence of advanced training and the individual is placed on a registry. The legislation identifying what are 'Basic' and 'Other' restricted activities' follows:

Basic authorized activities

14 A regulated member may, in the practice of physical therapy and in accordance with the standards of practice, perform the following restricted activities:

- (a) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform other invasive procedures on body tissue below the dermis or the mucous membrane for the purpose of wound debridement and care;
- (b) to insert or remove instruments, devices, fingers or hands
 - (i) beyond the point in the nasal passages where they normally narrow,
 - (ii) beyond the pharynx, or

¹ Physiotherapy Act, Revised statutes of Nova Scotia. 1998, Chapter 22

² Physiotherapy Act, Revised Statutes of Prince Edward Island, Chapter P-7

- (iii) into an artificial opening into the body.

Other authorized activities

- 15(1) Only a regulated member
 - (a) who is registered on the general register or on the courtesy register,
 - (b) who has provided evidence to the Registrar of having successfully completed advanced training approved by the Council, and
 - (c) who has received notification from the Registrar that the authorization is indicated on the general register or on the courtesy register, as applicable, may, in the practice of physical therapy and in accordance with the standards of practice, perform the following restricted activities:
 - (d) to cut a body tissue or to perform other invasive procedures on body tissue below the dermis or the mucous membrane for the purpose of needle acupuncture;
 - (e) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform other invasive procedures on body tissue below the dermis or the mucous membrane for the purpose of intramuscular stimulation and biofeedback;
 - (f) to insert or remove instruments, devices or fingers
 - (i) beyond the cartilaginous portion of the ear canal,
 - (ii) beyond the labia majora, or
 - (iii) beyond the anal verge;
 - (g) to reduce a dislocation of a joint;
 - (h) to use a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop;
 - (i) to order a form of ionizing radiation in medical radiography limited to x-rays only;
 - (j) subject to subsection (2), to order or apply non-ionizing radiation for the purpose of performing ultrasound imaging.
- (2) No regulated member shall perform the restricted activity described in subsection (1)(j) in respect of a fetus.

Restriction

- 16(1) Despite any authorization to perform a restricted activity, regulated members must restrict themselves in performing restricted activities to those activities that the member is competent to perform and that are appropriate to the member's area of practice and the procedures being performed.
- (2) A regulated member who performs a restricted activity must do so in accordance with the standards of practice.

In addition, Section 16 (2) applies to regulated members including the entry to practice physiotherapist, who may perform the basic restricted activities, and physiotherapist "who has provided evidence to the Registrar of having successfully completed advanced training approved by the Council" and "who has received notification from the Registrar that the authorization is indicated

on the general registrar or on the courtesy register, as applicable.”³

Jurisdictional Colleges’ Representation of Current Practice

Information from Registrars and the Canadian Forces⁴ provided the current position of practice in different jurisdictions, as related to each of the controlled acts proposed for consideration in Ontario. Information included activities both currently being sought and those suggested for consideration in the future, as summarized in the upcoming tables.

A) Activities Currently Being Sought for Approval in Ontario

Communicating a diagnosis identifying a physical dysfunction, disease or disorder as the cause of a person’s symptoms	
Province	College of Physiotherapy representation of whether currently practiced / approved
B.C.	Yes - a physiotherapy diagnosis.
Alberta	We do communicate a diagnosis in Alberta. The Health Professions Act presents “diagnosis” as one of the things that physical therapists practice. ⁵ Further, it is not a restricted activity in Alberta. Our practice statement includes “diagnosis and treat dysfunction caused by a pain, injury, disease etc.”
Saskatchewan	Yes. Within our Physiotherapy Act and reinforced by College By-Laws. “Physical therapists shall confine themselves to clinical diagnosis and management in those aspects of physical therapy in which they have been educated and which the profession recognize” and “physical therapists shall document the client’s history and relevant subjective information, the physical therapists’ objective findings, clinical diagnosis, treatment plan and procedures, explanation to the client, progress notes and discharge summary”. ⁶
Manitoba	Yes. This is part of what we can currently do and may not change with the anticipated health professions legislation. Diagnosis is authorized under regulations of the Physiotherapy Act: “A member must perform and document an initial assessment and evaluate all relevant data to identify problems and determine the physiotherapy diagnosis prior to intervention” and further that a physiotherapy intervention must “be based upon examination, evaluation, physiotherapy diagnosis and plan of care”. ⁷
Quebec	Yes - able to do this
New Brunswick	Yes. Always able to. Recently it was changed to ‘physiotherapy diagnosis’ with the support of the physicians in the province
Nova Scotia	Yes. Physiotherapists do communicate a diagnosis. There is no restriction in legislation or the Physiotherapy Act to making or communicating a diagnosis.
P.E.I.	Yes. The PEI Physiotherapy Act definition of physiotherapy includes “diagnostic assessment”
Newfoundland and Labrador	Able to provide a physiotherapy diagnosis - differentiated from a medical diagnosis
Canadian Military	Yes

3 Health Professions Act, Revised Statutes of Alberta. 2000, Appendix

4 Canadian Forces 2006 (revised)

5 Health Professions Act, Revised Statutes of Alberta. 2000, Chapter H-7 - Schedule 20 - Profession of Physical Therapists - Section 3

6 Saskatchewan College of Physical Therapists 2005, Bylaws Index, Section 1 (5) and (9)

7 Physiotherapists Act, Revised Statutes of Manitoba 1987. Physiotherapy Regulations - Schedule A - Standards of Practice Section 2 and 4 (1)

Treating a wound by including cleansing, soaking, irrigating, probing, debriding, packing and dressing a wound	
Province	College of Physiotherapy representation of whether currently practiced / approved
B.C.	Yes we have always done this
Alberta	Yes. We can do this - as a 'basic restricted activity' meaning authorized at the entry to practice.
Saskatchewan	Yes. This is within our scope
Manitoba	We can, but not the same terminology
Quebec	Yes. Wounds can be treated - but there are some challenges in inter-professional settings with occupational therapists and nurses. The tendency is for the nurses to take charge of wound care.
New Brunswick	Not doing now, but nothing to block it if competency is there
Nova Scotia	Yes, this is done
P.E.I.	Nothing to block this activity, but not currently carried out in the province
Newfoundland and Labrador	Nothing to block this activity, but not currently carried out in the province
Canadian Military	No. The med tech or physician assistant (PA) does this - but our physiotherapists have the ability and will respond if required in a war zone.

Administering by inhalation: oxygen, or a drug or substance that has been ordered by a regulated health professional with appropriate authority	
Province	College of Physiotherapy representation of whether currently practiced / approved
B.C.	Yes
Alberta	Yes. Administering oxygen is not a restricted act. The only restricted act is to prescribe anesthetic cases so the interpretation is that other agents can be administered.
Saskatchewan	Yes. Administering oxygen is within our scope - but not prescribing oxygen.
Manitoba	Yes, we administer oxygen
Quebec	No. In Quebec this is done by inhalation therapists
New Brunswick	Not doing now, but nothing to block it if competency is there
Nova Scotia	Yes
P.E.I.	Nothing to block this activity, but not currently carried out in the province
Newfoundland and Labrador	Nothing to block this activity, but not currently carried out in the province and would require review by the College
Canadian Military	Yes. Our physiotherapists take a special course on oxygen.

Putting an instrument, hand or finger beyond the labia majora or the anal verge for the purpose of assessment or treatment	
Province	College of Physiotherapy representation of whether currently practiced / approved
B.C.	We recommend one-to-one delegation. Some are doing this in women's health but are practicing under delegation from a physician
Alberta	Yes. We currently have a roster for incontinence - but this is changing as we have now moved this to the basic restricted activity - meaning authorized at the entry to practice.
Saskatchewan	Yes. Anal verge is within our scope (for coccyx manipulation). Labia majora is covered within our position statement on pelvic floor.
Manitoba	Yes
Quebec	Yes. This is part of entry to practice.
New Brunswick	Yes - may do if competency is there
Nova Scotia	Yes, this is done
P.E.I.	May be done - Nothing to block this activity, but not currently carried out in the province - but the College is open to a physiotherapist making a submission that includes evidence that they have taken courses to support competence.
Newfoundland and Labrador	Nothing to block this activity, but not currently carried out in the province and would require review by the College
Canadian Military	No. Not part of what is needed at this time.

Ordering the application of electromagnetism for MRI or sound waves for diagnostic ultrasound	
Province	College of Physiotherapy representation of whether currently practiced / approved <i>NOTE: Ordering of x-rays is also included here as it was discussed with other provinces at the same time as ordering MRI and diagnostic ultrasound</i>
B.C.	Yes - for diagnostic ultrasound
Alberta	Authority to order x-rays is currently being pursued. Regulations now include ultrasound imaging and we would like to add MRI.
Saskatchewan	No
Manitoba	We don't do this now. But we are working on it for physiotherapists working in Northern Manitoba. The issue is not authority to do it. This issue is accessing 'billing numbers for the activity.
Quebec	No. Not yet.
New Brunswick	Yes - may do if competency is there. Primary source for this is within interprofessional collaborative practice in some areas of the province where it is agreed that local service would be improved if physiotherapists with competency ordered X-Rays, MRI or diagnostic ultrasound. Where physiotherapists order x-rays, it is done with the approval and support of physicians, nurses and other providers in the area BUT - it is NOT through delegation - it is within the scope of physiotherapists. So as long as competency is there or developed, the physiotherapist may carry it out.
Nova Scotia	Not yet (ordering x-rays under medical directive/delegation at Annapolis)
P.E.I.	Not currently done - and would require physiotherapists to have special training to proceed.
Newfoundland and Labrador	No
Canadian Military	We are currently looking at including this as the US Military physiotherapists have this authority

Ordering lab tests	
Province	College of Physiotherapy representation of whether currently practiced / approved
B.C.	No authority for this
Alberta	No. Not authorized to do now and it is not part of our current discussion.
Saskatchewan	No
Manitoba	No
Quebec	No
New Brunswick	Not yet, but may do - if competency is there
Nova Scotia	No - not done yet
P.E.I.	Not done now
Newfoundland and Labrador	No
Canadian Military	No

B) Activities of Interest for Future Approval in Ontario

Setting or casting a fracture of a bone or a dislocation of a joint in an extremity	
Province	College of Physiotherapy representation of whether currently practiced / approved
B.C.	No. Was under discussion. But support from physiotherapists was not there.
Alberta	Yes
Saskatchewan	No
Manitoba	No. Not done now
Quebec	May be happening in some cases
New Brunswick	Yes - may do - if competency is there
Nova Scotia	Not done yet
P.E.I.	Not currently done - and would require physiotherapists to have special training to proceed. - not currently taught at the physiotherapy school in PEI
Newfoundland and Labrador	No
Canadian Military	A grey area. Physiotherapists will respond if they are the only one there. Otherwise the response is from a physician, med tech or PA

Ordering the application of electricity for electromyography and nerve conductive studies	
Province	College of Physiotherapy representation of whether currently practiced / approved
B.C.	No response
Alberta	Yes. It is not restricted in Alberta
Saskatchewan	No
Manitoba	No. We don't do this currently, but we do retrain muscle stimulation
Quebec	No. In Quebec there are technicians who do that with an order from a physician
New Brunswick	Yes - may do - if competency is there
Nova Scotia	No - not done yet
P.E.I.	Not currently done and would require physiotherapists to have special training to proceed
Newfoundland and Labrador	No
Canadian Military	Not done in the Canadian Military. The US military authorizes physiotherapists with advanced training to do this.

Prescribing drugs	
Province	College of Physiotherapy representation of whether currently practiced / approved
B.C.	No authority for this. It has not been discussed by the legislative committee of the College.
Alberta	The College had been pursuing authorization for prescribing, but has now elected not to pursue this in favour of the development of a collaborative working relationship with Pharmacists (who will prescribe and dispense on basis of information from the physiotherapist) through a memorandum of understanding. In essence, this arrangement will result in collaborative practice arrangements between physiotherapists and pharmacists to improve access to drug therapy indicated during the treatment of musculoskeletal disorders.
Saskatchewan	No
Manitoba	No
Quebec	No
New Brunswick	Yes - may do - if competency is there
Nova Scotia	No
P.E.I.	Cannot do
Newfoundland and Labrador	No
Canadian Military	We are looking at including prescribing anti-inflammatories like the US military.

Physiotherapy Scope of Practice Review

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