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EXECUTIVE SUMMARY

The Paramedic Association of Manitoba ("PAM") operates as the professional association for registered Emergency Medical Services ("EMS") providers licensed in Manitoba. Representing both rural and urban practitioners, PAM is committed to enhancing the role of paramedicine as a vital component in our health care system and promoting the highest quality of EMS and pre-hospital care possible. PAM's vision is to become a self-governing college responsible for all pre-hospital practitioners in Manitoba.

Paramedics are front-line health care providers educated and trained to assess a patient's condition and provide appropriate medical treatment and recommendations following approved and accepted medical protocols and guidelines. Typically, paramedics respond to emergency calls to assess and manage the patient(s) and provide care within their specific scope of practice. Paramedics must identify potentially life-threatening medical or traumatic conditions, obtain patient history, conduct physical patient assessments using appropriate methods, assess vital signs and utilize available diagnostic tests to develop a provisional working diagnosis. Paramedics begin appropriate medical treatment on-scene and, as necessary, continue medical treatment during transport to a hospital or alternate medical facility.

Assessing and treating patients in uncontrolled and weather-affected surroundings poses risks to patients and practitioners not experienced by other health professions. Multi-casualty triage, on-scene immobilization and emergency transport present risk of physical harm to patients.

Paramedics work within the EMS system which is intended to provide timely and safe response, sound medical assessment and treatment and medical transport services to citizens and communities in Manitoba. EMS provides out-of-hospital medical care to those with perceived urgent needs and delivers care as part of a system intended to attenuate the morbidity associated with sudden illnesses and injury. The core services in the EMS system are: emergency medical dispatch; emergency medical response and medical care; emergency medical transport; and inter-facility medical transport.

Paramedicine has evolved significantly over the past two decades, developing an increased and specialized body of knowledge through the National Occupational Competency Profiles for Paramedic Practitioners ("NOCP"), and realizing a growing trend toward a career profession. The increasing demand and responsibilities placed on paramedics within our health care system brings with it an increased potential for significant harm to patients.

The current regulatory framework (government regulation of both personnel and employers) no longer serves the best interest of the public as it does not adequately address transparency,

public accountability and competency within the profession. Whether considering enhanced education and entry to practice standards, mandating improved continuing competency requirements, or investigating a practice complaint, it has become increasingly difficult if not impossible to govern both the employee and the employer without experiencing a conflict of interest.

The members of the paramedic profession, based on their knowledge, skills and judgment, are best suited to govern their own profession in the public interest. Self-regulation through a Manitoba College of Paramedics will ensure public protection and accountability through processes defined in *The Regulated Health Professions Act* ("*RHPA*"), including public representation in decision making processes, the development of a continuing competency program and a formal complaints investigation process. A Manitoba College of Paramedics would regulate the practice of paramedicine and assure the public of the knowledge, skill, proficiency and competency of EMS practitioners.

Criterion #1 — Risk of Harm

1.1 Define what practitioners of the profession do. Specify what diagnoses (if any) and assessments they make. Specify the treatment modalities and services they provide.

Paramedics are front-line health care providers educated and trained to assess a patient's condition and provide appropriate medical treatment and recommendations following approved and accepted medical protocols and guidelines. Paramedics must determine theories of probable injuries or illness including differential diagnosis from which they can base their treatment plan.

Paramedics work within the EMS system, which is intended to provide timely and safe response, sound medical assessment and treatment and medical transport services to citizens and communities in Manitoba. EMS provides out-of-hospital medical care to those with perceived urgent needs and delivers care as part of a system intended to attenuate the morbidity associated with sudden illnesses and injury. The core services in the EMS system are: emergency medical dispatch; emergency medical response and medical care; emergency medical transport; and inter-facility medical transport. These are priority services which are central to the EMS system.

Although EMS can be viewed solely within the context of the core services of the system, EMS operates within the continuum of a larger provincial health care delivery system as only one of the core health services of the eleven Regional Health Authorities and Manitoba Health. EMS is a key component of the health care system and is intended to be fully integrated into the health care continuum as part of the primary health care level of care. The positive effects of EMS care are enhanced by linkages with other community health resources and integration within the health care system.

Typically, paramedics respond to emergency calls to assess and manage the patient(s) and provide care within their specific scope of practice. Paramedics must identify potentially life-threatening medical or traumatic conditions, obtain patient history, conduct physical patient assessments using appropriate methods of inspection, palpation, percussion and auscultation, assess vital signs and utilize available diagnostic tests to develop a provisional working diagnosis. Paramedics begin appropriate medical treatment on-scene and, as necessary, continue medical treatment during transport to a hospital or alternate medical facility.

Paramedics assess and treat patients following approved and accepted medical protocols and guidelines. Treatment modalities utilized by paramedics include upper airway patency and maintenance; oxygen delivery; manual and mechanical ventilation; measures to maintain hemodynamic stability including wound management, intraosseous and intravenous cannulation and instillation, cardio-electrical therapies including defibrillation, cardioversion and transcutaneous pacing;

basic care for soft tissue injuries; immobilization of suspected or actual fractures; and administration of medications.

Increasingly, paramedics are also being utilized to provide health care in atypical environments. Growing numbers of paramedics are working in more traditional health care settings in hospitals (especially emergency departments), urgent care centres, doctors' offices and long-term care facilities. Paramedics in Manitoba are now working in fixed wing and rotary medevac aircraft, and non-medical facilities such as the Main Street Project located in Winnipeg (a 24 hour crisis and emergency shelter).

Paramedics are also becoming involved in numerous public health initiatives (immunizations, illness and injury prevention programs, etc.). In some cases, paramedics "stand by" at mass gatherings (for example, concerts, sporting events, etc.) and high-risk activities (for example, fireground operations, etc.). In a number of other Canadian jurisdictions, paramedics are practicing in remand facilities and industrial camps (Alberta), personal care homes (Nova Scotia), as well as mobile health units serving urban and rural communities (Saskatchewan).

In 2001, the Paramedic Association of Canada ("PAC") developed the NOCP, defining the cognitive and psychomotor competencies required for entry to practice. The NOCP also serves to define the profession, promote national consistency in paramedic training and practice, and to facilitate labour mobility for practitioners.

In November 2011, an updated NOCP was approved by PAC and adopted by the Canadian Organization of Paramedic Regulators ("COPR") as a foundation document in the development of a national examination for paramedics. COPR is comprised of the self-regulating colleges and government or government delegated regulators from each of the ten provinces. This organization has adopted the NOCP as the basis for development of a common national entry to practice examination. It also used the competencies from the NOCP as a basis for jurisdictional comparison in their work on labour mobility for the profession.

The NOCP, a copy of which is attached at *Tab 1*, contains a set of four integrated competency profiles that define the practice competencies of paramedic practitioners and emergency medical responders within Canada. The competency profiles in the NOCP are used by both the Canadian Medical Association ("CMA") for the accreditation of paramedic education programs and by regulators as a framework for scope of practice and license reciprocity.

A competency profile is included for each of the following practitioner levels: Emergency Medical Responder; Primary Care Paramedic; Advanced Care Paramedic; and Critical Care Paramedic.

The competencies at each practitioner level are cumulative, in that each level includes, and exceeds, the competencies of the previous level. Furthermore, the competencies defined in these profiles are the minimum required at each practitioner level. Regulatory jurisdictions and employers can, and frequently do, exceed these requirements.

PAC forwards the NOCP for paramedics to the CMA for consideration in their accreditation process of educational programs for paramedics within Canada. Where supported by a provincial regulator and requested by an educational institution, the CMA may accredit paramedic education programs at the Primary Care Paramedic, Advanced Care Paramedic and Critical Care Paramedic levels. In order to be eligible for CMA accreditation, programs must identify the level that applies to them and must demonstrate that their graduates meet (or exceed) every specific competency listed in the corresponding profile.

Emergency Medical Responder ("EMR")

The primary focus of the EMR is to initiate immediate basic care to patients who access the EMS system. This individual possesses the knowledge and skills necessary to provide basic lifesaving interventions while awaiting additional EMS response and to assist higher level personnel at the scene and during transport. EMRs perform basic interventions with minimal equipment.

EMRs were part of the foundation upon which Canadian EMS systems were built. Today, they are often associated with volunteer emergency services organizations in rural and remote areas, and may be the first provider of emergency services in some communities. EMRs may be responsible for initial assessments, the provision of safe and prudent care, and the transport of a patient to the most appropriate health care facility. "First Responders" may be included within the EMR level.

In Manitoba, an EMR is licensed as a "Technician" once he/she has successfully completed a recognized training program in emergency patient care and transportation, and passed the regulatory written and practical examination.

Primary Care Paramedic ("PCP")

The primary focus of the PCP is to provide basic emergency medical care and transportation for critical and emergent patients who access the EMS system. This individual possesses the knowledge and skills necessary to provide patient care and transportation. PCPs function as part of a comprehensive EMS response under medical oversight and perform interventions with the equipment typically found on an ambulance.

PCPs may be casual or career paramedics associated with urban, suburban, rural, remote, industrial settings, air ambulance and/or military services. They constitute the largest group of paramedics in Canada and are expected to demonstrate excellent decision-making skills, based on sound knowledge and principles. Controlled or delegated medical acts identified in the PCP competency profile include defibrillation, intravenous cannulation and the administration of certain medications.

In Manitoba, a PCP is licensed as a "Technician Paramedic" once he/she has successfully completed a provincially recognized educational program in paramedicine at the primary care paramedic level, and passed the regulatory written and practical examination.

Advanced Care Paramedic ("ACP")

The primary focus of the ACP is to provide advanced emergency medical care and transportation for critical and emergent patients who access the EMS system. This individual possesses the knowledge and skills necessary to provide advanced patient care and transportation. ACPs function as part of a comprehensive EMS response under medical oversight and perform interventions with the basic and advanced equipment typically found on an ambulance.

ACPs are most often employed in urban, suburban, air ambulance, and industial settings. ACPs are expected to build upon the foundation of PCP competencies, and apply their added knowledge and skills to provide enhanced levels of assessment and care. This includes the added responsibilities and expectations related to an increased number of controlled or delegated medical acts available. Controlled or delegated medical acts identified in the ACP competency profile include advanced techniques to manage life-threatening problems affecting patient airway, breathing, and circulation. ACPs may implement treatment measures that are invasive and/or pharmacological in nature.

In Manitoba, an ACP is licensed as a "Technician-Advanced Paramedic" once he/she has successfully completed a recognized educational program in paramedicine at the advanced care paramedic level, and passed the regulatory written and practical examination. Such programs may require prior certification at the PCP level (or equivalent).

Critical Care Paramedic ("CCP")

CCPs are most often associated with large urban and/or air ambulance services. The CCP is expected to perform thorough assessments that include the interpretation of patient laboratory and radiological data. CCPs' high levels of decision-making and differential discrimination skills relating to patient care result in their implementing treatment measures both autonomously and after consultation with medical authorities. Many controlled or delegated medical acts are available to the CCP. Those identified in the CCP competency profile include the use of invasive hemodynamic monitoring devices and advanced techniques to manage life-threatening problems affecting patient airway, breathing, and circulation. CCPs typically implement treatment measures that are invasive and/or pharmacological in nature.

To be licensed, a CCP will have successfully completed a recognized educational program in paramedicine at the critical care level. This is the highest level of

paramedic certification available in Canada although it is not currently available as a license in Manitoba.

1.2 Specify the diagnostic tools, equipment and methods used by practitioners of the profession.

In order to grasp the magnitude of the tools, equipment and methods used by paramedics, one would be obliged to review the competencies detailed in Area 4 of the NOCP (*Tab 1*).

By way of example, paramedics use assessment methods which include: conducting single patient and multi-casualty triage; obtaining chief complaint and complete medical history including allergies and medications; conducting complete physical and body system assessments and interpreting findings utilizing inspection, percussion, palpation and auscultation; and assessment and interpretation of vital signs.

Paramedics also utilize multiple diagnostic tools, equipment and tests which include: stethoscopes; blood pressure measuring devices; temperature probes; percussion, palpation, auscultation and inspection; recognized neurological tests including the Glasgow Coma Scale, Cincinnati Stroke Scale and the Canadian Triage and Acuity Scale; pulse oximetry; end-tidal carbon dioxide monitoring; glucometric testing; and electrocardiograms.

1.3 a) Specify areas of practice, treatment modalities, and services which are performed exclusively by practitioners of the profession.

The pre-hospital work environment presents service, practice and treatment challenges exclusive to paramedics. Assessing and treating patients in uncontrolled and weather-affected surroundings poses risks to patients and practitioners not experienced by other health professions. Paramedics are considered by most health professions to be the subject matter experts in trauma scene spinal immobilization techniques utilizing long board and K.E.D. devices. Treatments such as needle cricothyroidotomy and needle thoracotomy are more often performed in the emergent pre-hospital environment.

b) Specify areas of practice, treatment modalities, and services which are also performed by other regulated health professions.

Paramedics perform treatment modalities and services that are carried out by a number of regulated health professions including physicians, nurses, respiratory therapists and midwives. These include: making and communicating provisional diagnosis to

patients or personal representatives; conducting and interpreting diagnostic tests including glucometry, vital sign assessment, SPO2 and CO2 monitoring, and electrocardiograms; performing procedures on tissue below the dermis; inserting airway devices into nasal passages and beyond the pharynx; administering substances by injection, inhalation and instillation; administering drugs; applying electricity for transcutaneous cardiac pacing, cardioversion, defibrillation; and managing emergency delivery of a baby.

c) Specify areas of practice, treatment modalities, and services which are also performed by other unregulated health professions.

There are none to our knowledge.

d) Specify areas of practice, treatment modalities, and services which are performed in conjunction with other regulated health professions.

Paramedics providing emergency medical services are part of the health system and part of the health care continuum. As such they are partnered in or integrated with other regulated health professions in delivering services. Increasingly, paramedics are being utilized to provide health care in atypical environments such as personal care homes and mobile health clinics. In some jurisdictions, paramedics are working in conjunction with other regulated health professions to provide primary or emergency health care. Of particular note is the increasing role of the "community paramedic". The community paramedic engages in an expanded role, working in non-traditional environments using their existing skills. Please see the December 2011 "*Community Paramedicine Submission to the Standing Committee on Health*" at *Tab 2* which compiles examples of community paramedicine both in Canada and internationally.

i) Provide specific information about the nature and extent of any overlaps in practice with other health professions. Include references to, and copies of, scientific literature and other published information.

Please see the answers to (b) and (c) above with respect to overlaps in practice.

Advancements in technology, an aging population, changes in demographics and challenges affecting heath care delivery have resulted in boundaries between health professions becoming more permeable. A report entitled *"Changes in Health-care Professions' Scope of Practice: Legislative Considerations"* published by the National Council of State Boards of Nursing in 2006 stated that "overlapping scopes of practice are a reality in a rapidly changing health care environment".

It may also be of assistance to consider the April 2009 report of the Health Council of Canada "*Teams in Action: Primary Health Care Teams for Canadians*" attached at *Tab 3*. The report notes that, in a number of different jurisdictions (i.e. Saskatchewan (p.28) and Nunavut (p.42)), paramedics have been welcomed as part of health care teams and have been responsible for the development of effective working relationships with hospital staff (physicians, nurses and pharmacists) as well as volunteers and community members.

ii) Provide specific information about which treatment modalities and services provided by your practitioners differ from other health professions. Include references to, and copies of, scientific literature and other published information.

Please see the answer to (a) above.

1.4 What professional titles do you recommend be restricted to members of your profession?

All titles listed in the NOCP should be restricted for use by members of the paramedic profession. This would include: Emergency Medical Responder; Primary Care Paramedic; Advanced Care Paramedic; and Critical Care Paramedic. It is contemplated that no person other than a member of a Manitoba College of Paramedics shall use those titles or any word, title or designation, abbreviated or otherwise, to imply that the person is a member.

1.5 Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health profession?

The Emergency Treatment Guidelines (the "Guidelines") established by Manitoba Health Emergency Medical Services branch ("MHES") provide a framework and reference point for care delivered by all EMS personnel in Manitoba. The Guidelines outline basic operational, assessment and treatment considerations to be followed by all licensed practitioners in the provision of their EMS duties and establish an acceptable standard for managing patients who are ill or injured. The Guidelines also make reference to more advanced care modalities to be considered by the EMS provider based on their individual license level and medical authorization through transfer of function.

The Guidelines became the standard of care in Manitoba on January 1, 2002 and are reviewed for approval by the Manitoba Emergency Services Medical Advisory Committee ("MESMAC"). MESMAC is comprised of a variety of physicians, EMS personnel, and others involved in the care of patients in the EMS environment.

A list of the Guidelines and the Guidelines themselves are attached at *Tab 4*.

The Emergency Treatment Protocols, commonly referred to as transfers of function (the "Protocols"), outline more advanced skills and interventions that may be practiced only under direct transfer of function authorization as delegated by their Medical Director based on the practitioner's education and licence level.

The Protocols were approved by the MESMAC for use by Manitoba licensed EMS personnel under their medical director's authority and direction. Most Protocols have been revised, to a greater or lesser degree, since their initial approval.

A list of the Protocols and the Protocols themselves are attached to this application at *Tab 5*.

Utilizing the Guidelines and the Protocols, paramedics refer patients to the most appropriate health facility or health care practitioner based on their assessment and provisional diagnosis. Examples of these referrals would include: stroke; STEMI; orthopaedic trauma; dialysis; burns; obstetrics; and trauma. In the sense that paramedics transport patients to the most appropriate health care facility dependent on need, referrals are made when the patient's needs are beyond the level of education, training and skill of the paramedic.

1.6 Specify which diagnoses/assessments, treatment modalities and services entail a risk of harm to patients/clients.

The pre-hospital work environment presents service, practice and treatment challenges exclusive to paramedics. Assessing and treating patients in uncontrolled and weather-affected surroundings poses risks to patients and practitioners not experienced by other health professions. Multi-casualty triage, on-scene immobilization and emergency transport present risk of physical harm to patients.

Paramedics perform a number of reserved acts as defined in the *RHPA* that entail potential risk of harm to patients: making and communicating provisional working diagnosis; performing procedures on tissue below the dermis including IV cannulation, chest decompression and cricothyroidotomy; inserting or removing instruments in nasal passages (nasopharyngeal airways and nasogastric tubes), beyond the pharynx (endotracheal tubes, combitubes) and into artificial openings in the body (stoma suction); administering substances by inhalation (oxygen, nitrous oxide), injection (medication, vaccination) and by instillation (IV solutions); administering drugs (oral, injection, inhalation and IV medications); application of electricity for cardioversion, defibrillation and transcutaneous pacing; and managing emergency delivery of a baby.

1.7 To what extent has the public's health, safety or well-being been endangered because your profession has not been regulated?

Manitoba paramedics are currently licensed by MHES in accordance with *The Emergency Medical Response and Stretcher Transportation Act*, a copy of which is attached at *Tab 6*. MHES oversees and enforces this legislation and the associated regulations which include the *Land Emergency Medical Response System Regulation,* the *Air Emergency Medical Response System Regulation* and the *Stretcher Transportation Services Regulation* - copies of which are attached at *Tabs 7*, *8*, and *9*. These documents govern both personnel licensing and EMS service licensing and operations.

PAM respectfully submits that the current regulatory framework (government regulation of both personnel and employers) no longer serves the best interest of the public. Whether considering enhanced education and entry to practice standards, mandating improved continuing competency requirements, or investigating a practice complaint, it has become increasingly difficult to govern both the employee and the employer without experiencing some conflict of interest.

With the advent of the NOCP, a defined and very specialized body of education and competence requirements was accepted for entry into the practice of paramedicine. As noted above, many of the procedures conducted by paramedics are now reserved acts as defined in the *RHPA*. Paramedics are recognized as health care providers who generally work in uncontrolled environments with very little direct supervision.

In light of all these circumstances, it is PAM's submission that the regulation of paramedics ought to be conducted by a Manitoba College of Paramedics to ensure the public is adequately protected in this field.

a) Provide examples of patients/clients being harmed by a practitioner who performed services incompetently or inappropriately. Include references to, and copies of, scientific literature and other published information.

As a voluntary membership professional association, PAM has been copied on written complaints regarding conduct and practice of paramedic practitioners. PAM is aware that some members have been reprimanded by employers for actions related to patient care and/or inappropriate conduct.

It is apparent that there is a lack of public understanding with respect to the appropriate entity which would investigate complaints against paramedics and, as such, it is extremely difficult to determine with any certainty whether paramedics have harmed patients as a result of incompetent or inappropriate practice.

b) How many complaints of harm to patients/clients has the association received each year for the past 10 years? How were complaints handled? What were the outcomes? Provide supporting documentation.

PAM has no regulatory jurisdiction over paramedics in the province, and as such does not currently have a complaints and disciplinary procedure. Our association has attempted but been unable to obtain data related to existing regulatory processes with respect to the outcome of public complaints and how these are currently handled.

Based on anecdotal data and discussion within the profession, it would appear that public complaints currently received by the government regulator are sent forward to employers to be dealt with in lieu of a peer or public investigation and appropriate discipline process. The data necessary to answer this question is therefore not available to PAM.

1.8 How will regulation decrease the risk of significant harm of the profession's treatments/services to patients/clients?

Paramedicine has evolved significantly over the past two decades, developing an increased and specialized body of knowledge (NOCP), and realizing a growing trend toward a career profession. The increasing demand and responsibilities placed on paramedics within our health care system brings with it an increased potential for significant harm to patients. The current regulatory framework does not address transparency, public accountability and competency within the profession.

Professional self-regulation is based on the concept that members of a profession, based on their knowledge, skills and judgment, are best suited to govern their profession in the public interest. Regulating through a self-regulatory paramedic body will ensure public protection and accountability through processes defined in the *RHPA*, including public representation in decision-making processes, the development of a continuing competency program and a formal complaints investigation process. The self-regulatory model will also allow for greater flexibility to address the increasing demands and changing practice directions of the profession.

1.9 What percentage of practitioners of the profession normally carries liability insurance coverage? Does the association urge its members to carry liability insurance coverage?

To our knowledge, current legislation requires paramedic employers to carry this insurance and very few, if any, paramedics in Manitoba carry their own liability

insurance. PAM currently offers liability insurance to member paramedics involved in first aid instructional work outside of their employment.

Once recognized as a regulated profession under the *RHPA*, a Manitoba College of Paramedics would ensure that all paramedics would be obliged to carry liability insurance.

Criterion #2 – Sufficiency of Supervision

2.1 Are practitioners of the profession directly or indirectly supervised in the performance of their duties and responsibilities by other regulated practitioners or administrators of regulated institutions? Which particular tasks/services, if any, are subject to a greater or lesser degree of supervision? Please explain how and why this supervisory relationship is no longer appropriate or adequate.

In the typical pre-hospital environment (air and ground), paramedics are not directly supervised in the provision of patient care. Paramedics are licensed practitioners expected to work autonomously without direct supervision and be held accountable for their actions. Assessment and appropriate medical treatment is provided in an independent setting following approved and accepted medical protocols and guidelines.

As noted above, paramedics are licensed by MHES and, as such, are required to file appropriate re-licensing documentation with MHES. Licenses must be renewed every three years. Paramedics have the option of completing a written and practical examination every three years or participating in the Alternate Route to Maintenance of Licensure Program ("ARML") on an annual basis, earning credits for patient contacts and completion of defined cognitive and psychomotor requirements. As ARML is an optional program for re-licensure, there are currently no formal or consistent continuing competency or professional development programs.

Under current legislation (*The Emergency Medical Response and Stretcher Transportation Act* and regulations thereunder), paramedics are required to practice under the authority of an ambulance service operator's medical director. A "medical director" is defined in the regulations as a duly qualified medical practitioner licensed to practice in Manitoba who has entered into an agreement with a holder of a license to operate a land or air medical response system.

The current paramedic scope of practice as defined in the Guidelines is limited in the sense that, although paramedics are expected to work autonomously in an unsupervised environment, the ultimate responsibility for all reserved and medical acts performed by the paramedic falls on the shoulders of the service operator's medical director as opposed to the paramedic.

The ability for a medical director to meet the requirements set out in the regulations with respect to transfers of function is becoming increasingly difficult for a number of reasons: more paramedics practicing under his/her medical license; higher patient contact numbers, more reserved acts added to transfers of function; and expansive geography of the regional service delivery model. It is PAM's submission that it is unrealistic to expect this form of arm's-length supervision to adequately protect the public and, in the circumstances, more responsibility ought to be shifted directly to the individual paramedic license holder, who would be subject to regulation by a Manitoba College of Paramedics.

2.2 Are practitioners of the profession currently performing reserved acts under the delegation of regulated professionals? Please explain how and why this situation is no longer appropriate or adequate.

The profession of paramedicine has undergone significant evolution over the past two decades. The educational requirements for a PCP have substantially increased both in content and length. In 1995, the accreditation for an Emergency Medical Technician (basic paramedic) was approximately 285 hours, whereas the PCP program today is a minimum of 1,020 hours.

Furthermore, the paramedic scope of practice has grown, as has the number and complexity of the transfers of function and reserved acts delegated by medical directors. The environment in which paramedics practice has evolved from a ground-based transport system to include flight and community paramedicine projects, such as the Main Street Project in Winnipeg.

Finally, the number of paramedics has increased from approximately 150 in the late 1990s to over 1,400 today, excluding EMRs, and it is anticipated that this number will continue to rise for the foreseeable future.

Paramedics are better educated and more entrenched in the health care system than was the case when the current process for the delegation of reserved acts was developed. It is unrealistic to expect the physician population to assume full responsibility for transfers of function currently practiced by paramedics; responsibility needs to be shifted to the license holder and the regulator to ensure appropriate accountability and proper protection of the public interest.

Criterion #3 – Alternative Regulatory Mechanism

3.1 Are individuals who practise this profession in Manitoba subject to regulation restrictions found in any other Act? Please specify.

Paramedics in Manitoba are subject to the legislation described in the answer to question 1.7 above. The regulations outline personnel licensing qualifications and requirements but do not adequately address ongoing competency maintenance for a health practitioner profession.

3.2 Has the profession in question considered regulation as a distinct subsection within a profession already being regulated and, if so, have they rejected this route? If so, what were the reasons for rejection?

PAM has not considered professional regulation as a subsection of an already regulated health profession as a viable option for a number of reasons. The typical practice of pre-hospital paramedicine is unique in that it is a relatively uncontrolled environment. Paramedics responding to medical and traumatic emergencies are called upon to assess and treat patients whenever and wherever their emergency occurs and are considered subject-matter experts in this form of health care. In just two decades, paramedicine has undergone significant growth in education, responsibility and professional numbers. The competency profiles developed by the profession and utilized for entry to practice (NOCP) are extensive. By today's numbers, there are approximately 2,000 paramedics and EMRs licensed in Manitoba; a number that requires significant oversight and which should be able to sustain its own regulatory body.

3.3 Has the profession in question considered joining other unregulated professions in a similar field who are or may seek regulation? If not, please explain why not.

PAM has not considered joining other unregulated health professions in seeking self-regulation as much of the practice of paramedicine is conducted in a unique environment. PAM is unaware of any unregulated health professions with any similar requirements.

3.4 Should self-regulation be determined not appropriate for the profession, what would be the most appropriate alternative form(s) of regulation? How might other applicable laws or existing standards meet the profession's needs?

Existing legislation and regulation related to EMS lacks professional accountability. Responsibility for practice competency rests with medical directors rather than the practitioner. There is no requirement for continuing education or ongoing competency maintenance but rather an option to choose a re-licensing method every three years. Public accountability in the form of a complaints investigation and resolution process is non-existent at the professional level, and is therefore handled for the most part by service operators.

It is the position of the applicant that the only acceptable option for accountability within the growing profession of paramedicine and the protection of the public interest, rests in self-regulation and inclusion in the *RHPA*.

3.5 What Acts in other Canadian, American and International jurisdictions regulate the profession? What is the statutory scope of practice in these jurisdictions?

Paramedics are self-regulated professions in Alberta, Saskatchewan and New Brunswick, and similar legislation has received royal assent in Nova Scotia. The Ontario Paramedic Association has filed an application for self-regulatory status in that province and is currently awaiting review by the Ontario Health Professions Regulatory Advisory Council.

The current Acts regulating paramedics in other Canadian jurisdictions are as follows:

Alberta	*Emergency Health Services Act*, R.S.A. 2008, c. E-6.6 and *Emergency Health Services (Interim Regulation)*, Alta. Reg. 76/2009, *Staff, Vehicle and Equipment Regulation*, Alta. Reg. 45/1999, *Health Disciplines Act*, R.S.A. 2000, c. H-2; *Health Professions Act*, R.S.A. 2000, c. H-7. The *Emergency Medical Technicians Regulation*, Alta. Reg. 48/1993, defines scope of practice.
British Columbia	*Emergency and Health Services Act*, R.S.B.C. 1996, c. 182. The *Emergency Medical Assistants Regulation*, B.C. Reg. 210/2010 defines scope of practice.

New Brunswick	*Ambulance Services Act*, S.N.B. 1990, c A-7.3. The Paramedic Association of New Brunswick has been given the authority to define scope of practice in its bylaws.
Nova Scotia	*Emergency Health Services Act*, S.N.S. 2005, c. 5. Note that the *Paramedics Act*, S.N.S. 2005, c. 10 has been passed but has yet to be proclaimed in force. Scope of practice in this province is defined through the paramedic employer.
Ontario	*Ambulance Act*, R.S.O. 1990, c. A.19 and *Ambulance Act*, O. Reg. 257/00, Schedules I, II, and III.
Prince Edward Island	*Public Health Act*, R.S.P.E.I. 1988, c P-30. The Emergency Medical Services Regulations, P.E.I. Reg. EC472/00, defines scope of practice in a schedule.
Quebec	*An Act respecting pre-hospital emergency services*, RSQ, c S-6.2 and *Regulation respecting the professional activities that may be engaged in within the framework of pre-hospital emergency services and care*, RRQ, c M-9, r 2;
Saskatchewan	*Paramedics Act*, S.S. 2007, c P-0.1 and *Ambulance Regulations*, RRS c A-18.1 Reg 1. The Saskatchewan Emergency Treatment Protocol Manual outlines a scope of practice for each license.

In Canada, five provinces (Alberta, British Columbia, Ontario, Prince Edward Island and Quebec) define scope of practice through regulations, Nova Scotia defines scope of practice through the paramedic employer, New Brunswick sets out its scope of practice in a bylaw and Saskatchewan uses its protocol manual.

A comprehensive listing of relevant American and international legislation and a listing of their respective scope of practice statements is not available to PAM.

With respect to the American jurisdiction, PAM has determined the relevant legislation for the five most populous U.S. States (California, Florida, Illinois, New York and Texas) as well as North Dakota and Minnesota. It may also be useful to consider the legislation in the United Kingdom and Australia.

American Legislation

California	Health and Safety Code, Division 2.5 (Emergency Medical Services) (a.k.a. the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act); California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical Paramedic), California Code of Regulations, Title 22, Division 9, Chapter 3 (Advanced Emergency Medical Technician); California Code of Regulations, Title 22, Division 9, Chapter 2 (Emergency Medical Technicians); California Code of Regulations, Title 22, Division 9, Chapter 8 (Prehospital EMS Air Regulations); California Code of Regulations Title 22, Division 9, Chapter 11 (EMS Continuing Education)
Florida	Florida Statutes, Chapter 64J-1 (Emergency Medical Services); Florida Statutes, Chapter 401, Part III (Medical Transportation Services)
Illinois	Illinois Emergency Medical Services Systems Act, 210 ILCS 50
Minnesota	Minnesota Statutes 2010, chapter 144E (Emergency Medical Services Regulatory Board) and Minnesota Rules, chapter 4690 (Ambulance Services)
New York	New York State Public Health Laws, Article 30 (Emergency Medical Services); New York State Emergency Medical Services Code, Title 10, Part 800
North Dakota	North Dakota Statutes, chapter 23-27 (Emergency Medical Services Licenses)
Texas	Texas Health and Safety Code, Title 9, Subtitle B, Chapter 773 (Emergency Medical Services); Texas Administrative Code, Title 1, Part 1, Chapter 157 (Emergency Medical Services - Part A)

International Legislation

Australia	*Public Health Act 2005* (Queensland); *Ambulance Service Act 1991* (Queensland); Health, Drugs and Poisons Regulation 1996 (Queensland);
United Kingdom	*Health Professions Order 2001*

A summary of all of the legislation is found in the attached tables at *Tabs 10* and *11*.

Criterion #4 – Body of Knowledge

4.1 Describe the core body of knowledge of the profession.

The core body of knowledge for paramedic practitioners is defined within a competency and curriculum blueprint developed by PAC and first published in June 2001. The NOCP contains integrated competency profiles that define the competencies of paramedic practitioners, and is utilized by the CMA for the accreditation of paramedic education programs across Canada.

The NOCP, at *Tab 1*, outlines eight areas of competence for entry to practice; Professional Responsibilities, Communication, Health and Safety, Assessment and Diagnostics (including pathophysiology), Therapeutics, Integration (full assessment and treatment), Transportation and Health Promotion and Public Safety. Each general competency includes a number of sub-competencies within it. These sub-competencies have been termed "curriculum blueprinting" because in effect they establish the curriculum outline for an education program to effectively meet the defined learning outcomes.

In 2001, PAC developed the NOCP, defining the cognitive and psychomotor competencies required for entry to practice. The NOCP also serves to define the profession, promote national consistency in paramedic training and practice, and to facilitate labour mobility for practitioners.

In November 2011, an updated NOCP was approved by PAC and subsequently adopted by COPR as a foundation document in the development of a National Examination for paramedics. COPR has adopted the NOCP as the basis for development of a common national entry to practice examination and has used the competencies from the NOCP as a basis for jurisdictional comparison in their work on labour mobility for the profession. Please see the attached excerpts from the COPR website at *Tab 12*.

4.2 Please provide a proposed scope of practice and relate it to this body of knowledge. Include references to, and copies of, scientific literature and other published information.

PAM proposes that paramedics registered with a Manitoba College of Paramedics carry out and perform the scope of practice, functions and tasks set out in the most recent NOCP for Paramedic Practitioners adopted by PAC.

4.3 For the following question, provide the rationale for your position including relating each to the body of knowledge, educational preparation and standards of practice. Also include references to, and copies of, scientific literature and other published information providing evidence for your argument and rationale.

With respect to the proposed scope of practice statement:

a) What reserved acts (if any) should members of the profession be authorized to perform?

Paramedics should be authorized to perform the following reserved acts:

- Making and communicating provisional diagnosis to patients or personal representatives - As diagnosis is defined in the *RHPA*, paramedics identify certain diseases, disorders and injuries prior to treatment and provide appropriate care and advice to patients and guardians;

- Conducting and interpreting diagnostic tests - including glucometry, vital sign assessment, SPO2 and CO2 monitoring, and electrocardiograms;

- Performing procedures on tissue below the dermis - IV and IO cannulation, chest decompression, and cricothyroidotomy;

- Inserting airway devices into nasal passages, beyond the pharynx and into artificial openings in the body – nasopharyngeal airways and nasogastric tubes, endotrachael tubes and combitubes, and airway stoma suction;

- Administering substances by inhalation, mechanical ventilation, irrigation and instillation – inhaled gas including oxygen and nitrous oxide, parenteral instillation of crystalloids and colloids, mechanical ventilation using air and oxygen;

- Administering drugs – oral, inhaled, injected, and IV/IO instillation;

- Applying electricity for transcutaneous cardiac pacing, cardioversion, and defibrillation; and

- Managing delivery of a baby – emergent delivery of a baby in the out-of-hospital setting.

The education and training necessary to perform these reserved acts is detailed in the NOCP.

b) What specific acts should practitioners be permitted to delegate to others? Specify the circumstances when members of the profession may choose to.

In the ordinary course of their practice, paramedics do not delegate to others.

c) What diagnostic/treatment modalities and services should members of the profession be permitted to perform?

Please see the answers to question 4.2 and (a) above.

d) What are the limitations of practice (if any) for members of the profession? Are there acts within this field of health care which practitioners should not perform? What diagnostic/assessment abilities, treatment modalities and services are not part of the scope of practice for members of the profession?

Please see the answer to question 1.1 above.

e) If you are proposing a new reserved act, please describe whether this act would be exclusive to your profession or whether there are opportunities for sharing of the act. If there are opportunities for sharing, please describe any consultation that has taken place with other impacted regulators.

PAM is not proposing any new reserved acts at this time.

Criterion #5 — Education Requirements for Entry to Practice

5.1 Does the professional association set standards of practice for diagnostic/treatment modalities and services based on the identified body of knowledge? Please explain. Are these standards enforced? Please explain. Provide a copy of the standards of practice and ethical guidelines.

The NOCP defines the assessment, diagnostic and treatment competencies for paramedics across Canada. As previously noted, the NOCP was first introduced in June 2001 and most recently updated in November 2011.

The CMA utilizes the NOCP in their accreditation process for educational programs for paramedics within Canada and may accredit paramedic education programs at the PCP, ACP and CCP levels. In order to be eligible for CMA accreditation, programs must identify the level that applies to them and must demonstrate that their graduates meet (or exceed) every specific competency listed in the corresponding profile contained in this document.

Standards of paramedic practice in Manitoba are defined in the Guidelines and Protocols, and competencies identified in these standards are based on those defined in the NOCP. For the reasons noted earlier, there is no effective enforcement mechanism currently in place for these standards.

PAM has been committed to the objective of raising the ethical standards of the profession. A code of ethics and professional conduct is an essential element of that process as it entrenches the commitment of all members of the profession to the protection of the public interest. In keeping with its obligation to promote the well-being, safety and appropriate medical treatment of patients, PAM has developed a draft Code of Ethics and Professional Conduct for its membership, a copy of which is posted on the PAM website and is attached to this application at *Tab 13*.

5.2 Identify and describe the educational and clinical/practical training programs available in Manitoba. Specify theoretical and clinical/practical experiences.

Paramedic educational programs currently require approval of MHES and include Southern Manitoba Academy of Response Training (EMR only), Red River College, Criti Care EMS Inc., Winnipeg Fire Paramedic Service/Manitoba Emergency Services College for Primary Care Paramedic ("MESC") and any CMA accredited program for an ACP.

Criti Care EMS Inc. does not provide a detailed program description of their PCP course, however they do publish a course overview, attached at *Tab 14*, which describes the didactic modules, lab work and simulation, and the various clinical and practicum provisions.

In Brandon, MESC offers a combined Firefighter-Paramedic education program and describes the PCP education as follows:

> The Primary Care Paramedic program prepares the individual for work in the prehospital field. The course consists of both theory and a significant amount of hands on time with equipment to allow our students to become comfortable prior to starting their clinical and ambulance practicum time.
>
> An added bonus for our students is they receive certification in a recognized trauma course from International Trauma Life Support (ITLS). ITLS is an international organization with Chapters throughout the world. This course is required by many jurisdictions prior to being eligible for registration.
>
> Clinical rotations are completed in the emergency departments in hospitals within major centres in Manitoba. All ambulance practicums are completed with our partnering organization – Winnipeg Fire Paramedic Service. Our students spend a minimum of 18 shifts on the ambulance and average approximately 75 calls during that time.

The Southern Manitoba Academy of Response Training teaches only EMR programs and describes its program as consisting of three components: the theory component which consists of text book and work book material to be read and completed prior to the classroom sessions; the classroom component which can be done by either completing the part time evening course or the full time BLITZ course (1 week); and, following either method of the EMR Classroom training mentioned above, there are also skills nights that integrate the theory and practical skills to combine knowledge and skills.

Red River College provides both EMR and PCP education; their programs are described as follows:

> EMR - 160 hour program
>
> Acquire the knowledge and skills necessary to provide pre-hospital care in accordance with the Manitoba Health Emergency Services Treatment Guidelines. The course incorporates a theoretical and practical component. Topics include emergency medical services, ambulance operations,

anatomy and physiology, patient assessment, basic life support, medical and trauma emergencies, special patient considerations, childbirth, pharmacology, tubes maintenance, pulse oximetry, and environmental injuries.

PCP - 1 year Certificate program

This program provides you with the academic and clinical experience to work in the exciting and challenging field of emergency medical services. The program runs 11 months consecutively with a completion date in July/August. The academic component will be delivered in class in Winnipeg and by eTV delivery to various remote locations throughout Manitoba. All students will be required to attend practical skills labs at the College's Notre Dame Campus in Winnipeg. Field practicum experience will be conducted in rural/northern Manitoba and in Winnipeg. This program will be based on the national occupational competency profile for Paramedicine - Primary Care Paramedic, and will support employment opportunities in rural and northern Manitoba.

Educational programs are required to assess competency within academic, simulated, clinical and working precepted performance environments. Theoretical and clinical/practical education and experiences are required to meet or exceed those identified in the NOCP.

a) Describe how the profession's body of knowledge and approach to diagnostic/treatment modalities and services are taught in this program.

The NOCP is used by all approved paramedic educators in Manitoba as a basis for their educational program. Current Manitoba PCP Program Requirements, as defined by MHES, require the education program to be CMA-accredited with a minimum of 1,020 education contact hours, 60 hospital clinical hours and 240 hours of precepted work experience - a copy of the Requirements is attached at *Tab 15*. Educational programs must incorporate the Guidelines and the Protocols into their program curriculum and practicum education.

MHES currently requires ACP education programs to be CMA-accredited, however no minimum contact, clinical or precepted work experience hours have been mandated for these programs.

There is currently no CCP education program available in Manitoba.

b) Relate the education and training to the diagnostic/assessment abilities, treatment modalities and services.

Education and training is based on the NOCP and must incorporate the Guidelines and the Protocols. As noted above, the Guidelines and Protocols currently form the basis of paramedic practice in the province.

c) What percentage of the practitioners of the profession has Manitoba education and training?

According to 2011 data provided by MHES, approximately 95% of the paramedics licensed in Manitoba have been educated and trained in our province.

d) What percentage of the members of the Association has Manitoba education and training?

Based on the MHES data regarding Manitoba practitioners and our membership demographics, we estimate that in excess of 95% of the members of PAM have been educated and trained in Manitoba.

5.3 Identify and describe each of the Canadian, American and International academic education and clinical/practical training programs available to persons seeking to enter this profession. Specify theoretical and clinical/practical experiences.

Each provincial paramedic regulator in Canada outlines the educational requirements for initial licensure in their jurisdiction. The CMA currently accredits 73 paramedicine education programs in the country based on the profession's NOCP. The CMA requires programs to cross-reference all NOCP competencies to their program elements, including proof of didactic, simulation, clinical rotation and field preceptorship.

With respect to the American and International programs, PAM is not able to comprehensively identify and describe these programs.

a) Describe how the profession's body of knowledge and approach to diagnostic/treatment modalities and services are taught in these institutions.

Please see the answer to question 5.3 above with respect to Canadian education programs. PAM is not aware of the manner in which American and International education programs are taught, and it is our understanding that Canadian regulators access this information on a case by case basis when required.

b) Relate the education and training to the diagnostic/assessment abilities, treatment modalities and services.

Please see answer to (a) above.

c) What percentage of the practitioners in the province has Canadian, American or International education and training?

According to data provided by MHES, approximately 5% of licensed paramedics in Manitoba have received education and training outside Manitoba, with less than 1% receiving their education outside Canada.

d) What percentage of the members of the Association has Canadian, American or International education and training?

Based on the MHES data regarding Manitoba practitioners and our membership demographics, we estimate that approximately 5% of our members received their education and training outside Manitoba, with less than 1% having been educated outside of Canada.

5.4 Identify and explain the major differences between programs in different jurisdictions.

Most Canadian paramedic education programs are now based on the NOCP, but not all are required to have CMA accreditation. Paramedic education programs exist in both the public and for-profit environment, although the majority of programs are now housed in college or technical school settings.

Program length for the PCP education program ranges from four months at the Justice Institute in British Columbia to two years in Ontario college settings and three years in Quebec. ACP education is taught in both public and employer settings across the

country. CCP education is available in a limited number of college and hospital settings.

a) What academic/vocational/technical education/training, post-graduate and continuing education/training is required by the association for membership?

Membership in PAM is open to Manitoba licensed paramedics and students enrolled in a recognized paramedic education program within the province. It is significant to note that license holders in Manitoba are not currently required to participate in any continuing education or competency maintenance programs. This is an issue which a Manitoba College of Paramedics would need to address.

b) What academic/vocational/technical education/training, post-graduate and continuing education/training is required by employers?

Service employers are required by legislation to employ only licensed paramedics but, again, license holders in Manitoba are not currently required to participate in any continuing education or competency maintenance programs to maintain licensure.

c) What academic/vocational/technical education/training, post-graduate and continuing education/training is required by other Canadian jurisdictions for registration by a regulating body?

Alberta, Saskatchewan and New Brunswick paramedics are self-regulated, and each of these regulatory bodies requires registrants to undergo continuing education and competency maintenance programs defined by their colleges/associations. Alberta and New Brunswick incorporate a self-directed assessment and learning plan development into their ongoing registration requirements.

5.6 Do you contemplate levels of registration? Please explain.

The levels of registration for regulated members should be consistent with the levels outlined in the NOCP: Emergency Medical Responder; Primary Care Paramedic; Advanced Care Paramedic; and Critical Care Paramedic. In addition, it is anticipated that there may be regulated associate members who are paramedic students.

Criterion #6 – Leadership's Ability to Favour the Public Interest

6.1 Why is it in the public interest to regulate the profession?

Although the profession is currently regulated by MHES, it is in the public interest to move the profession to a model of self-regulation and create a Manitoba College of Paramedics.

Health professions are regulated to ensure the public is protected when they seek or receive health care. Self-regulation is based on the concept that members of a profession, based on their knowledge, skills and judgment, are best suited to govern their profession in the public interest.

With the advent of the NOCP, a defined and very specialized body of education and competence requirements was accepted for entry into the practice of paramedicine. Today, many of the procedures conducted by paramedics are considered to be reserved acts as defined in the *RHPA*. Paramedics are recognized as health care providers, generally working in uncontrolled environments with very little direct supervision. Taking all of this into consideration, coupled with the growth of the profession in the past decade, it is logical to suggest that self-regulation of paramedics through a college under the *RHPA* should ensure the public is adequately protected in this field.

The current regulatory framework (government regulation of both personnel and employers) no longer serves the best interest of the public. Whether considering enhanced education and entry to practice standards, mandating improved continuing competency requirements, or investigating a practice complaint, it has become increasingly difficult if not impossible to govern both the employee and the employer without experiencing a conflict of interest.

Paramedic self-regulation under the *RHPA* would allow flexibility for the profession to adopt evidence-based best practices and policy and ensure accountability, transparency and public protection. A Manitoba College of Paramedics would regulate the practice of paramedicine and assure the public of the knowledge, skill, proficiency and competency of members in the practice of emergency medical services.

6.2 Provide evidence of the profession's commitment to the public interest through its communications, policies and/or procedures.

PAM's mission statement outlines a commitment to promote the well-being, safety and appropriate medical treatment of our patients.

Among our goals, we strive to foster relationships and work collectively with other allied health care agencies and organizations to promote the highest level of care for all patients, to support and facilitate continuing education for EMS providers and to encourage and assist in the development of EMS education that is relevant, comprehensive and accredited.

PAM has: promoted the need for ongoing and continuing professional education; developed and made available to all Manitoba paramedics continuing education packages consistent with the current provincial optional route for re-licensing; promoted improvement to paramedic education by advocating development of post-secondary programs like the Red River College PCP program, participating in provincial education review and advisory committees, and supporting the accreditation of paramedic education; developed a draft Code of Ethics and Professional Conduct; participated in numerous committee roles supporting improved patient care and EMS service delivery, including the Medical Transportation Coordination Centre development committee, the Provincial EMS Framework Project, the provincial education advisory sub-committee and the ARML review committee; and implemented a license and education/competency tracking system for members.

6.3 Does the association have a complaints and disciplinary procedure? Please describe this briefly. How long has this procedure been in place? How effective has it been?

PAM has no regulatory jurisdiction over paramedics in the province, and as such does not currently have a complaints and disciplinary procedure. Our association has attempted but been unable to obtain data related to existing regulatory processes with respect to the outcome of public complaints and how these are currently handled. Based on anecdotal data and discussion within the profession, it would appear that public complaints currently received by the government regulator are sent forward to employers to be dealt with in lieu of a peer or public investigation and appropriate discipline process.

It is our submission that the current complaints and disciplinary procedure does not transparently protect the public interest - that is, there is no effective means by which the public can be assured that complaints are dealt with systematically in a manner which will ensure public safety. As a profession with an expanding role in the health care system, paramedics ought to be subject to a transparent complaints and discipline process consistent with the *RHPA*.

6.4 Explain how the proposed scope of practice is in the public interest and provides adequate public protection while not unduly restricting the public's choice of health care providers.

The scope of practice proposed by PAM is specifically tied to the education and competencies set out in the NOCP. The traditional environment in which paramedics do their work does not restrict public choice. Moreover, paramedics who work in a non-traditional setting will augment current system resources and are therefore enhancing public choice. In light of the nature of emergency health care and the services provided by paramedics, it is difficult to envision any public choice restrictions.

Criterion #7 – Membership Support, Willingness to be Regulated and Likelihood of Complying with Regulation

7.1 Do the members of the profession/association want self-regulation? Please describe any consultation process and the response/results achieved.

Self-regulation has been a topic of discussion among paramedics in Manitoba since 1983, first as members of the Manitoba Pre-hospital Care Personnel Association and then under the leadership of the Manitoba Pre-hospital Professions Association. In 2001, PAM was formed with the vision "to become a self-governing, self-regulating society responsible for licensure of pre-hospital practitioners in the Province of Manitoba".

PAM currently has 1,060 members, all of whom have voluntarily registered in an organization with a clear mandate to seek self-regulation for paramedics. The topic of self-regulation has been canvassed regularly in PAM's newsletter through Canadian Emergency News. Please see selected excerpts at *Tab 16*.

A web page specific to the issue of self-regulation for Manitoba paramedics was developed in the fall of 2009 and that link was provided to PAM members through PAM's newsletter and email. A PowerPoint presentation entitled "*Understanding Professional Self-Regulation*" was developed to educate paramedic practitioners and is attached at *Tab 17*.

In addition, PAM's executive has met with PAM members across the province to speak about the need for self-regulation for paramedics. These meetings date back to 2003 and have been well-attended by paramedics. Please see the attached PAM PowerPoint presentation entitled "*Paramedic Self-Regulation and 'What will it mean to me?'*" at *Tab 18*, which was delivered to approximately 200 paramedics attending the InterAct EMS Conference held in October 2010 in Winnipeg. This presentation

was also delivered at the 2010 PAM Annual General Meeting and was made available for general review on our website.

PAM also travelled across Manitoba in 2006 and 2007 with representatives of Manitoba Health who were conducting education sessions on the *Emergency Medical Response and Stretcher Transportation Act*. Please see the attached PowerPoint presentation highlighting PAM's emphasis on the promotion of self-regulation for paramedics in Manitoba at *Tab 19*.

While a formal survey of the profession has not been conducted, PAM is confident that our members support self-regulation for paramedics on the basis that the public's interest will be better protected through a more professionalized EMS system with improved pre-employment education and career level positions.

Most recently, our members have been apprised of the pending application through a mailing sent out on February 14, 2012, a copy of which is attached at *Tab 20*.

PAM has also obtained letters of support from MGEU, the union which represents both rural and urban paramedics in Manitoba and the Paramedic Association of Canada, copies of which are attached at *Tabs 21* and *22.*

7.2 Do the other organizations (if any) which represent practitioners in similar or related areas of health care agree with the need for regulation? Please explain and describe any consultation process undertaken with other related health professions. What were the responses/results achieved?

In 2002, the Emergency Medical Service Chiefs of Canada ("EMSCC") was incorporated as a national forum for information gathering, policy development and coordinated action by the leadership of Canada's EMS systems. This group works under an operating mission "To Advance and Align EMS Leadership in Canada". In 2006, EMSCC published a paper entitled "*The Future of EMS in Canada; Defining the New Road Ahead*". This report was intended, in part, to provide policy-makers with an understanding of how government might enable a strategic picture of the EMS of the future. At page 34, the report expressed the organization's support for the goal of self-regulation for paramedics as a means of medical accountability. The report suggested that EMS ought to seek self-regulation in order to "take its position alongside physicians, nurses, respiratory therapists, and pharmacists as essential, professional, front-line health care practitioners". Please see excerpts of the report at *Tab 23*.

PAM has also conducted informal consultations with the College of Registered Nurses of Manitoba and the College of Physicians and Surgeons of Manitoba. These organizations have expressed their support in principle for our application and their letters are attached at Tabs *24* and *25*. Both the College of Midwives of Manitoba as well as the Manitoba Association of Respiratory Therapists are aware of our application and we anticipate they will also be supportive of our application.

7.3 How many persons practice this profession in Manitoba? How many of these practitioners belong to an association? Please provide independently assessed and verified figures, if possible.

As of September 14, 2011, according to figures provided by Manitoba Health, there were 598 people licensed as a Technician (EMR), 1,296 people licensed as a Technician Paramedic (PCP) and 116 people licensed as a Technician Advanced Paramedic (ACP).

Current to December 2011, PAM members constituted 280/598 (47%) of the first group, 701/1,296 (54%) of the second group and 79/116 (68%) of the third group.

7.4 Explain how members of the profession will be able to assume the responsibilities, including the expense, of administering their own College? (if applicable)

Based on current numbers, a Manitoba College of Paramedics would have a membership of approximately 2,000 licensed providers. This number exceeds the membership numbers of many of Manitoba's existing health colleges.

Members recognize the need to assume roles of responsibility within the College structure and many have already come forward to show their willingness to participate. Please see a sample of the letters of support for our application attached at *Tab 26*.

7.5 What would be the proposed fee structure for College members?

While it is exceedingly difficult to precisely fix a fee structure at this time, PAM is committed to maintaining a fee at the minimum appropriate rate while still allowing for the expected costs of the transition to a College. Current models in other Canadian jurisdictions range from a low of $395 per year in New Brunswick to $425 in both Alberta and Saskatchewan.

PAM is currently considering an estimated initial fee structure of approximately $300 to $400 per member.

Criterion #8 — Economic Impact of Regulation

8.1 Describe the effect of regulation on practitioner availability, education and training programs, the enhancement of quality of the profession's services, and prices, access and service efficiency.

PAM is of the view that self-regulation will not have a negative impact on the provision of paramedic services in any of these areas. On the contrary, self-regulation ought to ensure the profession remains strong and responsive in areas such as practitioner availability and standardized education, while enhancing service quality by strengthening professional responsibilities and public transparency.

Paramedic self-regulation exists today in Alberta, New Brunswick and Saskatchewan. The change in regulatory status in these jurisdictions does not appear to have resulted in any negative impact on access to paramedic practitioners or service efficiency.

The current legislation controlling emergency medical services came into force in 2006 and introduced new personnel licensing requirements that saw the onus for license retention shift from the employer to the practitioner. At that time, there was a shift in employer philosophy that saw most service operators seek employees who were already educated, trained and licensed as opposed to hiring staff and providing post-employment paramedic education. Although it was thought significant changes like these might negatively impact the availability of paramedic practitioners, the opposite has proven to be true. Manitoba has more licensed and employed paramedic practitioners today than at any time since the shift from "volunteer EMS operations" took place over a decade ago.

It is anticipated that a small number of current practitioner license-holders may choose to leave the profession once a registration fee is imposed, but it is PAM's perception that those paramedics entering the profession today are career-oriented and unlikely to opt out of the profession based solely on a licensing or registration fee.

Professional self-regulation stands to have a positive impact on the education and training of paramedicine practitioners. As the profession has evolved, so too has the depth and specialized body of knowledge necessary to practice within the profession. It could be argued that it is becoming increasingly difficult for government to set and monitor standards for education and practice, and that the profession has developed and continues to develop the specialized expertise to better determine these requirements. Paramedics and educators can be more responsive to change in a self-regulating environment than would be allowed in a government regulatory model.

Self-regulation under the *RHPA* will enhance the quality of paramedic service in a number of ways. As professional practitioners, paramedics will be motivated to assume greater responsibility for their conduct and competency. Continuing education and ongoing competency maintenance will be a requirement rather than an option.

Complaint and disciplinary processes will be transparent and promote increased public confidence that they are receiving safe, effective and skilled emergency medical services.

Criterion #9 — Public Need for Regulation

9.1 Is there a demonstrable public need for regulating the profession? Please describe any process undertaken to determine the public need and the response/results achieved.

In the past decade, paramedic education and training has become more specialized. The demands placed on paramedics in our health care system have increased. Centralization of many specialized health services means paramedics are tasked with making more critical decisions about appropriate patient transport destinations and are often caring for patients for extended periods of time. Paramedics are assuming increased responsibility in the practice of controlled acts.

As a result of all this, and the increasing conflict associated with the current model of government regulation of service operators and practitioners, there is a need for regulatory change to best meet public need and safety.

Recognizing the need for change, MHES and key stakeholders (from the Regional Health Authorities, the EMS Network, the Regional Health Authorities of Manitoba and PAM) addressed the need for self-regulation in recommendations made in the April 2008 "*Provincial Emergency Medical Services Framework: Planning Document*" (the "Planning Document"), a copy of which is attached at *Tab 27*.

The Planning Document reflects the work of the Provincial Emergency Medical Services Steering Committee and Project Team, which was tasked with developing a framework for decision making to guide the development of the EMS system in Manitoba. There were 23 goals and objectives identified including a recommendation that "Professionalization of the EMS system will be supported through pre-employment education, career level positions and self-regulation".

9.2 Describe any agreements on trade and/or mobility that may be affected by regulation of the profession. What are the plans to address these issues?

In November 2011, the updated NOCP was approved by PAC and subsequently adopted by COPR as a foundation document in the development of a National Examination for paramedics.

COPR, formed in 2009, is comprised of the self-regulating Colleges and government or government-delegated regulators from each of the ten provinces. This organization has adopted the NOCP as the basis for development of a common national entry to practice examination. It also uses the competencies from the NOCP as a basis for jurisdictional comparison in its work on labour mobility for the profession. COPR brings a national perspective to issues concerning not only labour mobility but also education, regulation, operations and professional practice.

A Manitoba College of Paramedics would participate as the province's regulating body in place of the current government regulator and would ensure compliance with the Agreement on Internal Trade.

CONCLUSION

PAM is firmly of the view that there is a public interest in ensuring the availability of regulated services provided by the paramedic profession. It is clear that the services of the paramedic profession provide a recognized and demonstrated benefit to the health, safety and well-being of the public. It is our respectful submission that paramedics have the financial and human resources to sustain self-regulation. A future Manitoba College of Paramedics will be committed to compliance with *The Regulated Health Professions Act* and the principles of natural justice. The paramedic profession can and will put aside their own interests to act in the interests of the public and ensure the skilled and safe provision of emergency medical services for all Manitobans.

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Paramedic Association of Manitoba
Jodi Possia, Chair

February 17, 2012

GLOSSARY

ACP	Advanced Care Paramedic, licensed in Manitoba as a "Technician-Advanced Paramedic"
ARML	Alternate Route to Maintenance of Licensure Program
CCP	Critical Care Paramedic, license not currently available in Manitoba
CMA	Canadian Medical Association
COPR	Canadian Organization of Paramedic Regulators
EMR	Emergency Medical Responder. licensed in Manitoba as a "Technician"
EMSCC	Emergency Medical Service Chiefs of Canada
EMS	Emergency Medical Services
Guidelines	Emergency Treatment Guidelines
Medical Director	A duly qualified medical practitioner licensed to practice in Manitoba who has entered into an agreement with a holder of a licence to operate a land or air medical response system
MESC	Manitoba Emergency Services College for Primary Care Paramedic
MESMAC	Manitoba Emergency Services Medical Advisory Committee
MHES	Manitoba Health Emergency Medical Services

NOCP	National Occupational Competency Profiles for Paramedic Practitioners
PAC	Paramedic Association of Canada
PCP	Primary Care Paramedic, licensed in Manitoba as a "Technical Paramedic"
PAM	Paramedic Association of Manitoba
Protocols	Emergency Treatment Protocols, commonly referred to as Transfers of Function
RHPA	*The Regulated Health Professions Act* of Manitoba

PARAMEDIC ASSOCIATION OF MANITOBA

Application for Designation as a Regulated Health Profession under *The Regulated Health Professions Act*

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