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March 27, 2023

Re: Submissions to the Law Amendments Committee regarding Bill 256: *Patient Access to Care Act.*

Please accept the attached submission of Dr. D.A. Grant for the College of Physicians and Surgeons of Nova Scotia.

Yours truly,

D.A. (Gus) Grant, AB, LLB, MD, CCFP, ICD.D
Registrar & CEO

DAG/CJ

Submissions to the Law Amendments Committee regarding Bill 256: Patient Access to Care Act

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Submitted on behalf of the College of Physicians and Surgeons of Nova Scotia (CPSNS)
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Submissions to the Law Amendments Committee regarding Bill 256: Patient Access to Care Act. Submitted on behalf of the College of Physicians and Surgeons of Nova Scotia (CPSNS)

I am Dr. Gus Grant, the Registrar of the CPSNS. I am joined by Dr. Keri McAdoo, the Deputy Registrar.

The College's mission is public safety. It is through the lens of public safety that we do our work of licensing physicians, setting the standards for medicine, investigating complaints, and regulating over 3300 physicians and residents licensed in our province.

All in this room are united to public safety. The government is correct to focus on access to care as our most pressing issue. The College wants to be a part of the solution, to help deliver on its goals.

As long-standing family physicians, we worry for those without primary care. Lack of access, and lack of access to primary care in particular, is not safe. Government, the public, and all in this room can clearly see that.

As we all seek to expand access to care, the College can help government ensure that the care is safe.

There is much in Bill 265 that already aligns with the work of the College. We already turn completed licence applications around quickly, always in less than 5 days. We license readily physicians from other provinces. Access to care is more important than application fees, which are waived by the Act. As Registrars, Dr. McAdoo and I have broad authority to waive license requirements, a discretion exercised frequently.

As a regulator, we have concern about some language in the Act and how that language might affect the path forward. For the Act to achieve its goals safely, particularly if the Act stands unamended, robust and thoughtful regulations will be needed.

Let me offer some examples:

1. To improve access to care, the act seeks to bring expansion of scopes of practice into regulations, so as ensure all health professionals can work **"to the full extent of their training"**.

Bringing scope of practice under regulations is a very good idea, particularly for professions hamstrung by scopes defined in their Act. We support and applaud this initiative. Regulations can be changed more quickly than Acts and, if collaboratively developed by government and the professions, can allow defined scopes of practice to keep pace with the evolution of health care.

We applaud the underlying idea here – to enable professionals to maximize their contributions.

The language chosen is to let professionals work to "the full extent of their training". Those who work in health care, however, would prefer different wording.

Health professionals and regulators speak in the language of competence, of which training is but one component. We include experience, currency of experience, demonstrated ability, continuing professional development. Put it this way: 25 years ago, I was trained to deliver babies. I delivered my last one 20 years ago. I am trained to deliver babies. I am not competent to deliver babies and I shouldn't be licensed to do so today.

It is a small example, but one that underscores the need for the voice of the profession in the room when regulations are drafted.

2. To improve access to care, the act seeks quick licensure for physicians elsewhere in Canada who are **"in good standing"**.

To the lay person, this sounds perfectly reasonable. We agree with the underlying idea. Not only do we agree with it, it is already our practice and our legal duty. The recent agreement to launch the Atlantic Register has taken this further than anywhere in Canada.

While we support the idea, we have concerns about the language. "In good standing" means different things to different organizations. There are organizations for which "in good standing" simply means "fees are paid and up to date". The suspended practitioner or the one subject to criminal investigation would be "in good standing". As regulators, we would prefer language like "independently license to practise without condition, restrictions, or undertakings".

Again, this is a small example where the voice of the profession, in this case regulators, will need to be heard when regulations are developed.

Regarding Physician Mobility and International Medical Graduates:

The College supports physician mobility and all efforts to welcome competent physicians to NS.

Most would think there is but one type of medical licence. There are many. In addition to licence types, many physicians have conditions and restrictions on their licence, put in place for reasons of safety. The medical licenses bodies work hard to tailor licensure to allow physicians to safely maximize their contributions. When a physician changes provinces, those safeguards need to travel too. The driver licensed to drive a passenger vehicle in Ontario cannot come and drive a big rig in NS.

I would like to draw attention to section 8 (1) (d). This section confers to government the authority to identify international jurisdictions where Canadian license requirements could be waived.

We already waive requirements for family physicians from Australia, UK, Ireland, and for all certified physicians from the US as of right. We are the first province in Canada to do so. We took this step because their training, their practice, and their certification processes are safe and substantially similar to ours.

We are keen to explore whether other jurisdictions merit the same treatment and would welcome collaborating with government in that pursuit. In our experience, it is far more complex than most might think.

With our current approach, Nova Scotia's doorway is wider and pathway to long-term licensure is shorter than anywhere else in Canada. Safeguards are necessary.

It is tempting to think that biology is biology, and therefore medicine is medicine. Medicine is so much more than biology. Medical training and practice vary greatly around the world, particularly in areas where culture, law, and medicine overlap. Arriving physicians to Nova Scotia often come with different training and approaches to contraception, informed consent, human rights, mental health, abortion, opioid prescribing, and medical assistance in dying. For such reasons, these physicians need oversight and evaluation.

To set arriving physicians up for success in practice, welcoming, orientation, supervision, support, and mentorship are needed.

For this reason, the College developed the Welcome Collaborative, with government support. Next month, 19 new physicians, mostly from Nigeria, will spend intense days with the College building relationships and learning about medicine in Nova Scotia. It is hard to come to a place to practise where you look and sound different than most of their patients, while learning a new and foreign system. It is not in the public or the physician's best interest to simply issue them a Full licence and let them find their own way.

We share and support the Government's goals. It is only fair to acknowledge government has an incredibly difficult job – access to care is not just a Nova Scotia issue, it is worldwide. As this is our life's work, we can assure you one thing: there are no easy solutions.

This Bill brings both good intentions and good ideas. To achieve them, we would propose:

a. This Committee add language to this Bill;

   i. Declaring the Bill can only be effective when the enforcing regulations are developed;

   ii. Ensuring the regulations <u>shall</u> be developed with the participation and concurrence of the GIC and the affected professional regulatory authorities; and

   iii. Ensuring the Bill and Regulations must be followed as a whole.

Through the lens of safety and with the knowledge of practice, the College has long collaborated and supported thoughtful expansion of scopes of practice for allied professionals. One need only look at the expansion of contributions made by physician assistants, nurse practitioners, greater pharmacist, and paramedic scope of practice over the last decade, all of which involved engagement with the College.

We urge this committee to recommend the suggested amendment so we can move forward together to help solve the pressures we are all feeling.

All of which is respectfully submitted.

D.A. (Gus) Grant, AB, LLB, MD, CCFP, ICD.D.
Registrar, CPSNS