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COMMITTEE

ON

HEALTH

Tuesday, August 13, 2019

LEGISLATIVE CHAMBER

Dalhousie Medical School
and its Role in Health Care Sustainability

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WITNESSES

Dalhousie University

Dr. David Anderson - Dean,
Faculty of Medicine

Dr. David Gass - Head,
Department of Family Medicine

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, AUGUST 13, 2019

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Hon. Gordon Wilson

VICE-CHAIR
Suzanne Lohnes-Croft

SHERRI MITCHELL (Acting Legislative Committee Clerk): Order, please. Good afternoon. This is the Standing Committee on Health. In the absence of the Chair and Vice-Chair, the committee needs to elect an Acting Chair from among the members who are present, for the purpose of today's meeting only. The floor is now open for nominations. Ms. Miller.

HON. MARGARET MILLER: I nominate Keith Irving.

SHERRI MITCHELL: Are there any other nominations? With that, Mr. Irving will chair today's meeting.

KEITH IRVING (The Chair): Welcome to the Legislative Assembly and the Standing Committee on Health. Today we will be hearing from Dr. David Anderson, the Dean of the Faculty of Medicine at Dalhousie University; as well as Dr. David Gass, Head of the Department of Family Medicine. Both are from Dalhousie Medical School. We'll be discussing its role in health care sustainability. Welcome to our witnesses today.

A reminder for everyone to have your phones off or on vibrate. In case of emergency, please exit through the back door to Granville Street and gather across the street.

I'll now ask our committee members to introduce themselves.

[The committee members introduced themselves.]

THE CHAIR: I'll now turn it over to our guests to provide a few opening comments. Dr. Anderson.

DR. DAVID ANDERSON: Thank you for inviting us to appear before the committee today. My name is David Anderson. I'm the Dean of the Faculty of Medicine at Dalhousie University. I'm pleased to be joined by Dr. David Gass, who is the interim Head of the Department of Family Medicine at Dalhousie University.

Dalhousie Medical School celebrated its 150th anniversary in 2018. We have a long-standing tradition of producing excellent physicians, performing world-class research, and contributing to our communities and society. In my presentation, I will focus briefly on some of our efforts in each of these areas in my presentation.

Our medical school currently trains 108 medical students per year in our four-year undergraduate program: 78 in Nova Scotia, and 30 at our Dalhousie Medicine New Brunswick campus. This number will rise to 124 students next year, with the recent announcement of the expansion of the medical school class by 16 Nova Scotian students.

At Dalhousie, we are committed to producing medical graduates who meet the needs of our province. This has resulted in two significant strategic shifts in undergraduate medical education over the past few years. First, we recognize the need for family physicians in Nova Scotia. As a result, we are producing a much greater emphasis of our training on family medicine. Our goal is that 50 per cent of our graduates will pursue careers in this discipline. Over the past year, we've seen the number of our graduating students selecting family medicine residencies increase from 25 per cent to 40 per cent, and we look forward to seeing this figure rise in upcoming years.

Second, we recognize the need for physicians outside of the urban Halifax area. As a result, we're providing our students more educational opportunities throughout the Province of Nova Scotia. For example, we're excited that in September 2019, for the first time, four medical students will be spending their entire third year of medical school training under the direction of physicians in Cape Breton in our Longitudinal Integrated Clerkship program. Our goal is that one-third of our students will participate in Longitudinal Integrated Clerkships around the province over the next four years.

Dalhousie Medical School also trains graduate physicians to become family physicians and specialists. We have over 50 residency training programs, and currently we're training over 500 residents across the Maritime Provinces. In family medicine, we have five sites in Nova Scotia that train 46 residents each year in a two-year program. This includes a new site in the North Nova region that is training six residents in Truro, New Glasgow, and Amherst, which opened July 1, 2019. Other family medicine training

programs are based in Cape Breton, the Annapolis Valley, southwestern Nova Scotia, and Halifax. Also, on July 1, 2019, 15 new specialty residency positions were opened to address the specialty needs of communities outside of Halifax.

Giving our students and residents learning experiences outside of Halifax accomplishes two major goals: first, it provides them with excellent educational experiences; and second, it attracts our graduates to live and work in community settings around our province. Students and residents are now being trained to work in areas around the province that need them the most.

Research is an integral component of Dalhousie Medical School's mission to advance quality of health and health care in the Maritimes and beyond. Not only does research lead to a better understanding of the prevention and treatment of disease, it also provides health care providers and policy-makers with information that is essential for making real improvements to clinical practice, health service delivery, and public health policy.

Over the past five years, the faculty of Dalhousie Medical School has received over $300 million in research funding, accounting for about 40 per cent of Dalhousie's total research funding. This is the largest amount of research funding awarded to any faculty in any university in Atlantic Canada. Our researchers are not only finding innovative solutions to address important health issues facing Nova Scotians, they are creating jobs and positively impacting our economy. Furthermore, having a medical school with excellent educational programs and research opportunities is key for the recruitment and retention of family physicians and specialists who make up our university faculty and play such an important role in health care in our province. The quality and breadth of care these physicians provide make it an uncommon event for Nova Scotians to have to leave the province to seek care for medical services not available provincially.

Dalhousie Medical School also has a major societal role to help address the needs of under-represented groups. We are increasing our efforts to recruit and retain more diverse medical students, including Nova Scotians of African descent, Mi'kmaq, and other Indigenous groups. Over the past eight years, Dalhousie Medical School has had an affirmative action program that supports the admission of Nova Scotians of African descent and Indigenous students. This year, we are welcoming six Nova Scotians of African descent and five Indigenous students into our first-year class.

The Faculty of Medicine is directing its focus on the admission of status Mi'kmaq students. Our affirmative action programs have to date resulted in us recruiting a very small number of status Indigenous peoples and no status Mi'kmaq students from Nova Scotia. Addressing this issue has become the focus of our social accountability and admission teams.

Dalhousie is also committed to ensuring that students throughout Nova Scotia have the opportunity to attend medical school. With the addition of 16 seats, we are committed that our students in Nova Scotia reflect the population balance between urban students in the Halifax region with those from communities around the province. A focus on diversity, equity, and community representation will lead to improved and more inclusive health care for all.

Teamwork is an important component of running our medical school. Our clinical faculty in Nova Scotia all have appointments with either the Nova Scotia Health Authority or the IWK. Much of our training and research occurs in NSHA and IWK facilities, and we rely on the excellent collaboration and support of these organizations.

I also want to credit the Department of Labour and Advanced Education and the Department of Health and Wellness for their roles in supporting our work. We also work closely with Doctors Nova Scotia and the provincial college in efforts to support the training of physicians in our province and in innovative programs such as the family medicine Practice Ready Assessment Program.

We are well aware of the challenges facing the Nova Scotia health care system, and with the continued support of government and our partners, we will continue to produce excellent medical practitioners to help the needs of society and contribute to a strong and sustainable health care system for Nova Scotia.

Thank you very much for the opportunity to speak with you here today. We look forward to answering your questions.

THE CHAIR: Thank you very much, Dr. Anderson.

I have just been made aware of a legislative rule here, (5A), “With the exception of the Attorney General, who shall serve as Chairman of the Law Amendments Committee, no Minister shall be appointed to a Standing Committee established for the purpose of considering matters normally assigned to or within the purview of that Minister or that Minister’s Department.”

It’s a bit of a grey area. Comments from the committee. We have Mr. Kousoulis, who is responsible for universities, but the topic is with respect to health care sustainability. He’s not the Minister of Health and Wellness. I would like some opinions from the committee on whether we’ll allow Minister Kousoulis to remain, and then I will make my decision. Are there any concerns with Minister Kousoulis being here? Ms. Adams.

BARBARA ADAMS: I think given the importance of the topic, we would value his input, so I have no objection to him remaining.

THE CHAIR: Are there any other comments? Ms. Miller.

MARGARET MILLER: I believe Minister Kousoulis can add to this conversation. We'll have some good questions, and we also value his input.

THE CHAIR: Thank you. With that advice to the Chair from committee members, we will proceed.

We will now move to questions from the various caucuses. We'll begin with the PC caucus for 20 minutes. Ms. MacFarlane.

KARLA MACFARLANE: Thank you so much for that input and for being here today as well. It's great to know that Dalhousie - 150 years, that was quite a celebration. We thank you for all the hard work that you have been doing. It doesn't go unnoticed. I want you to know that. We're very proud that Dalhousie is in Nova Scotia. It's worldly known, and I have had a lot of relatives go there over the years. We're very proud to have it here.

We are entering a very delicate time in our health care system. Coming from a rural area like Pictou West, many of us, including myself, don't have a doctor - thousands and thousands, to be honest. One of our biggest concerns and questions that I hear a lot from constituents is, why are the doctors who are graduating from Dalhousie not staying here? Why do they exit? I'm just wondering if you could give me a bit of feedback on why you think they're exiting, leaving this province, and not staying here to practise.

[1:15 p.m.]

DAVID ANDERSON: I would tend to look at things a little bit differently in framing a response here. I think what I would like to focus on is what we're doing to try to keep Dalhousie doctors here in Nova Scotia and to have them live and work here. Two factors that are very important in the recruitment and retention of physicians, particularly in community settings outside of Halifax, outside of our major urban setting - providing the students with training experiences in the community. We are doing that in two major ways.

First, in our undergraduate, in our medical school program, which is a four-year program, we have developed a program where students are spending their entire third year of medical school, which is really their formative year, where they interact with patients, work in hospitals, work in clinics, interact with family physicians and specialists, under their supervision - we've developed a program which is called the Longitudinal Integrated Clerkship program where students are spending that entire year in the community setting. We have experience with this program at our Dalhousie Medicine New Brunswick campus, where 50 per cent of our students are trained outside of Saint John, New Brunswick, and we're opening our first Longitudinal Integrated Clerkship program next month in Cape Breton as a start to get our students out in the community for their training.

Our target is that one-third of our students, or probably 30 of them, over the next four years will receive this formative clerkship experience entirely in the community setting. The reason that's important is that evidence would show elsewhere in the country and around the world that students who receive this type of community training are highly likely to enter community practice when they finish their graduation, when they become physicians. Whether it's family physicians or specialists, there is a high likelihood that physicians who are trained in this type of program will work in a community setting when they enter practice. Our efforts now are really to maximize that opportunity around the province, provide our students with that great educational experience, and have them be attracted to work in the community setting when they're finished their training.

We also have a family medicine residency training program. Dr. Gass can speak to this as the head of the department. In training our graduates to become family physicians, we have five of these programs in Nova Scotia. Four of them exist in communities around the province - in Cape Breton; in the North Nova area, which is Truro, Amherst, and New Glasgow; in southwest Nova Scotia, in the Yarmouth region; and in the Annapolis Valley. Again, these residents, the graduate physicians, are provided with training experiences in the community to immerse them in the community and to attract them to take up residence and to work in those areas when they're finished.

Our data has shown that over the past five years, when Dalhousie graduates enter our family medicine residency training programs, one of those five programs, we have an 83 per cent recruitment rate. So, 83 per cent of our Dalhousie grads who are entering those family medicine residency training programs enter practice in Nova Scotia, as compared to only about 50 per cent if the graduates come from other medical schools and do their residencies at Dalhousie. Those students are much more likely. By having more Dalhousie students doing more residencies, and with our efforts here on distributed educational programs, we believe we're going to continue to recruit and retain more physicians in this region in the years to come.

KARLA MACFARLANE: Just given the limited amount of time we have, I will try to get to my questions as directly as I can, and perhaps may inject once in a while, too, so that I can move on to the next question.

As of today, as we speak right now, in Nova Scotia, we have 185 unfilled doctor positions. Can you tell me why you believe we have 185 unfilled positions?

DAVID ANDERSON: In partnership with the Nova Scotia Health Authority, the IWK, and the provincial government, we are working and doing what we can about recruiting and retaining physicians in our province. We think that's a very positive development. The Nova Scotia Health Authority is hiring a physician recruiter who is going to be working with our graduates, looking to find places for them to work and train when they're finished their training. We want to make it as attractive as possible to keep graduates and physicians who are coming out of our program in Nova Scotia. I think it is paying off. Our data would support that things are moving in the right direction. With the

increased medical seats, the increased residency training programs, we are going to be producing more physician graduates to work in our province.

KARLA MACFARLANE: Quickly, how do you think it's paying off, when we have anywhere from 60,000 to 100,000 people without a doctor?

DAVID ANDERSON: It's incremental gains. I think our role in the system is looking at the moderate and long-term solution to the sustainability of health care. Producing more graduates and recruiting more young people and having them stay in our province to work is going to be part of the solution of addressing the shortages that you point out.

KARLA MACFARLANE: We live in a province of less than a million people. Let's say you have 12 individuals who graduate at the same time. Their credentials, let's say, are the same. Right now, as we speak today, we have 11 ER closures in this province. We have four different zones. The doctors who graduated together, if we have a doctor working in an ER in Yarmouth who wants to go to work in Cape Breton as a locum while someone goes on vacation, they have to go through a mound of paperwork in order to ensure that their credentials meet that zone. We have four zones. It's really frustrating to see that system, that policy, in place. I'm wondering if you have a comment on that and if you feel that's a necessary step that has to be taken for doctors to move in their own province to work at other facilities.

DAVID ANDERSON: I work closely with colleagues at the Nova Scotia Health Authority, with Doctors Nova Scotia, with the provincial college, and with government. That specific issue is not under my domain to manage or to deal with. I have confidence that everyone has the best of intentions to make this provincial health care system work. I would support that I think those are good questions to ask those individuals, but I think they're doing their utmost to work in improvements in health and health care delivery in the province.

KARLA MACFARLANE: You indicated that we have over 50 residency training programs and are currently training over 500 across the Maritime Provinces. Do you have a breakdown of those 500?

DAVID ANDERSON: I don't have the breakdown of those numbers in front of me. If that would be information you would like to see, I would be happy to provide that information to the committee.

THE CHAIR: Thank you, Dr. Anderson. Please send that on to us following the meeting.

KARLA MACFARLANE: Thank you, we would look forward to that information later on. I'm just wondering, how many Dalhousie graduates have the Province of Nova Scotia actually retained in the last five years.

DAVID ANDERSON: It's a very important question. Since 2010, we have embarked on a project which is called the located project, where we are tracking the path of every graduate of our program. In five years' time, I'm going to be able to give you a great answer as to where those people are, but unfortunately, it takes time for physicians to develop. It's six years for a family physician to develop and over 10 years for a specialist to develop. To systematically give you those numbers, I don't have a robust systematic answer right now.

KARLA MACFARLANE: That's fine. Do you know even in the last year?

DAVID ANDERSON: The years don't line up. Doctors go into residencies that are anywhere from two to six years. It's a complex answer to a simple question. What I would tell you is the most robust and perhaps important information for the committee is what's happening with our family medicine residency graduates.

Over the past five years of the family medicine residency training graduates who did their medical school training at Dalhousie, 83 per cent of them established a practice in Nova Scotia. If a graduate came from outside of Nova Scotia and went into one of those residency positions, we're retaining about 50 per cent of them. Again, our strategy here for the long-term recruitment and retention of family physicians is to get Dal grads to go into Dal family medicine residency positions and have them stay in our province to work and live when they're finished.

KARLA MACFARLANE: A number of individuals that I know who have been trained internationally are wanting to come back home. They want to hang their hat - they want to live here and have a family. They're meeting a lot of barriers as international graduates. I'm just wondering if you could elaborate a little bit on why you think it's so difficult for them to find residency programs.

DAVID ANDERSON: There are residency positions available for international medical graduates. At our Dalhousie family medicine program, we have six designated seats for international medical graduates so they can apply to those positions. Those graduates are also eligible to enter what's called the second iteration of the residency matching process. Last year, there were four international medical graduates who joined one of our family medicine programs through that match. Ten international medical graduates have come to the Dalhousie family medicine program over the last year to begin training.

We also have two positions available within our medical school so that international medical graduates can come to medical school and do their third and fourth years of training, graduate from Dalhousie Medical School, and then pursue residencies from there. That is also a popular pathway for international medical graduates to look at those opportunities.

KARLA MACFARLANE: In saying that, will the addition of residency spaces actually help internationally trained doctors?

DAVID ANDERSON: There is a matching process; across the country, graduates of Canadian medical schools enter a Canadian matching process. At Dalhousie, if there are unfilled residency positions after the first round of the match, which is only open to Canadian medical graduates, then international medical graduates are eligible to apply. Last year, four international medical graduates were successful in receiving residency training positions in family medicine at Dalhousie through that process.

[1:30 p.m.]

KARLA MACFARLANE: Do you see a need for an increase in residency programs?

DAVID ANDERSON: I think the members of the committee can appreciate that adding additional residency training positions is a huge undertaking and investment, and we are incredibly grateful to the Province of Nova Scotia for adding 25 new residency training positions over the last year - starting July 1, 2019.

With those additional seats, it offers additional training capacity for Nova Scotian graduates and for international graduates.

KARLA MACFARLANE: Going back to the training capacity, it doesn't give us comfort in knowing that they're staying here, does it?

DAVID ANDERSON: As I indicated, in our family medicine residency training programs, we have recruited and retained over 83 per cent of Dalhousie graduates that have gone into family medicine. We are being very successful at recruiting and retaining physicians through that program.

KARLA MACFARLANE: Just 83 per cent of how many?

DAVID ANDERSON: From 2013 to 2017, 60 of 72 Dalhousie medicine graduates who did the family medicine residency training program have stayed and practised in Nova Scotia. Of 63 graduates who graduated from a medical school that was not Dalhousie, 36 of those 63 have stayed and practised in the province. Those are the numbers over the past five years.

KARLA MACFARLANE: We know that we have a growing population, an aging population, so what is Dal doing in preparation to ensure that we will have enough doctors? People are concerned for the future knowing this.

THE CHAIR: Order, please. That concludes the time for the PC caucus. We'll now proceed to the NDP caucus. Ms. Martin.

TAMMY MARTIN: Thank you for being here and providing us with some very useful information.

In the 2019 #DalMedForward status update, you indicate that the 2019 graduating class matched only 40 per cent of the students to family medicine. First, if you could clarify, how many of those students matched to residencies in Nova Scotia, and how does the 40 per cent match rate to family medicine compare to other medical schools across Canada?

DAVID ANDERSON: I would have to get you that information on the breakdown. It is the vast majority at Dalhousie, but I can get you those figures.

Across the country, it does vary from school to school that Dalhousie has a responsibility for producing and dealing with all of the physician needs in this province and with much of the physician needs in the Maritime Provinces, so we are responsible and accountable for making sure we have adequate numbers of specialists and family physicians. There are some schools in the country that work in a province where there may be six medical schools and one particular medical school has a focus in family medicine, where 75 per cent or 80 per cent of their graduates may go into that discipline, but there will be other schools in the province where that number will be lower. The number is between 40 per cent and 50 per cent that would be typical if we looked at the 17 schools across the country. That information is tracked, however, and I can provide an exact breakdown to the committee if that's of value.

THE CHAIR: I think the committee would be interested in that information. You can add that to your list today. Thank you.

TAMMY MARTIN: The status update indicates that the Faculty of Medicine investigated the reasons as to why this match was so low. Can you speak to why Dalhousie medical students are overwhelmingly selecting specialized services rather than general practice?

DAVID ANDERSON: We met with our students and had focus groups to identify why they were choosing not to go into family medicine, and they gave us some excellent feedback on that. One of the issues was around how we organized our medical education, that it has been a specialty-focused educational experience where most of the lecturers and many of the tutorial leaders and teachers that the students would see, particularly early in their medical school training, are specialists. The students told us they didn't have the mentorship of family medicine early in their formative years, where they often bond with

physicians and say, that's what I want to be, I want to be like Dr. Gass, and that sort of thing.

We are addressing that. We are getting our family doctors more involved in our educational experiences early in their training. We are providing more rotations in family medicine. We now have a mandatory six-week rotation in family medicine in our first year to ensure that students get early and excellent exposure to family medicine. We have had a very gratifying uptake of family physicians in the province who are incredibly interested in participating in that program.

We also have a week of what's called rural week. At the end of first year, our students go to communities outside of Halifax and work with a family physician for a week. The students often will say this is their best week in medical school, when they see doctors in the community setting, working in real life. That has been a factor. Providing our students more educational experience later on in their training, in their third and fourth years, was also felt to be a gap and that we did not provide enough educational experiences in the clinical setting in meeting the needs of our students. That is something that we're addressing predominantly through this distributed educational program.

We have been working with family physicians around the province and with the Nova Scotia College of Family Physicians. We have made it clear to them, and they completely agree, that they are the best recruiters to attract students to enter family medicine. Again, it's having those role models around the province who are passionate about the importance of family medicine that is an important factor in recruiting physicians to enter this discipline.

The third factor that was particularly an issue two years ago was the publicity in the media and in physician circles around family physicians being a valued and important career option for physicians was being questioned. Again, I think that is family physicians and dealing with the college and with our Department of Family Medicine, and I would ask Dr. Gass to speak to this as well.

Our students want positive experiences. They want to be excited and challenged and think that these are great career opportunities for them. We've sent that message and it has been well received and embraced by family physicians around the province. Changing the culture and the attitude around the importance of family medicine has been a strategic effort. With those three factors, the number of students that went into family medicine went up from 25 to 40 per cent in one year. We are continuing to work and address those issues over time and expecting to see that number rise further.

THE CHAIR: Dr. Gass, would you like to add something to this?

DR. DAVID GASS: I would support what David has said and also highlight that among the work we've been doing within the department is to actually increase our recruitment of community family physicians into teaching opportunities for the students in medical school, as well as increasing their participation in the residency program, which we've achieved as we've added new sites over the last five to seven years. That's very important.

The second is, we're challenging our faculty to find ways to ensure that they are visible and tutoring and leading the education, as David says, to the early students in the first two years. I think we've had some success with that, and the result is that it did go up last year. We have further work to do on that and we have a particular strategy in place to ensure that family physicians who are able to take part in the undergraduate program - which means you do have to be adjacent to Halifax - are encouraged and supported.

TAMMY MARTIN: I guess two quick things then. First of all, what year is the 25 per cent from that you say it was at 25 per cent for students going into family medicine and it jumped to 40 per cent?

Secondly, if this Longitudinal Integrated Clerkship was so successful in New Brunswick, why are we just rolling it out in Nova Scotia now?

DAVID ANDERSON: The numbers - 2018 was the residency match when it was 25 per cent; it was 2019 that it went up to 40 per cent.

The Longitudinal Integrated Clerkship started with the inception of Dalhousie Medicine New Brunswick in 2010 when we made the strategic decision that we were going to start this program from day one with that medical school site in New Brunswick. It was a novel and innovative thing for us to do. We wanted to see how it worked, whether it was well accepted by the students and the communities. It has turned out to be a phenomenal success.

It takes time, however, to get this program in place. It usually takes two years by the time we decide that we want to do this in order to get the program up and running. We've got to identify physicians that are agreeable to taking the students on as preceptors. We've got to ensure that the resources are available within the communities to manage these programs, so there is usually a two-year time lag in getting new programs up and running. Those are the factors - just the reality of dealing with these comprehensive programs.

I became dean in 2015, and I started working on implementing this program shortly after I took over as dean. We've been working with the Department of Health and Wellness and the Department of Labour and Advanced Education to get the logistics worked out. Then we started negotiating with communities. It is moving forward in a timely manner, and I think success in Cape Breton is going to solidify success in other places around the province.

TAMMY MARTIN: Keeping along those lines, I wonder how this is successful in recruitment and retention. To that end, when students are not choosing to stay here, what is it that we're missing with recruitment and retention? What could we be offering them in order to stay or why are they turning down our offers?

[1:45 p.m.]

DAVID ANDERSON: I think it's important for the committee to be aware of the distinction in our two different training programs. We have an undergraduate medical education program, which is for four years, and students become doctors at the end of that. They then enter residency training programs where they will become either family physicians in a two-year program or they will become specialists in a five-year program.

The Longitudinal Integrated Clerkship program that I mentioned is in our undergraduate training. It is the third year of their training. The value of that program is that it's highly likely that students that come out of that program are going to work in the community setting when they're finished, usually in careers in family medicine or in what we term generalist specialties. Then there are the residency programs.

With the strategy that we're doing, encouraging our students for a career path in family medicine, increasing the size of the medical school in Nova Scotia, increasing the number of residency training positions and then having very high rates of retention of students and residents that go down that path is going to help us address the current shortage that we have of physicians in the province.

TAMMY MARTIN: The Canadian medical student graduates with a debt load of more than $160,000. We know from Canadian data that students with higher debt loads are more likely to cite financial considerations as a major impact on their practice location and specialty. In your opinion, is there adequate funding in place to ensure that more doctors choose to practise family medicine in Nova Scotia?

DAVID ANDERSON: There are active programs in Nova Scotia to financially compensate our graduates that are going into family medicine, particularly in the community setting. I can provide you with that information. These are not our programs. This is the Department of Health and Wellness offering loan forgiveness, bursary programs to support students going into practice, particularly in community settings in the province.

Those factors are important to our graduates and I completely agree that it is a staggering debt load that some of our graduates are carrying. Support from the provincial government is absolutely making a big difference in helping those students make decisions to stay in Nova Scotia.

TAMMY MARTIN: Is there something that we could be doing more to encourage doctors from Nova Scotia to practise family medicine, financially or otherwise?

DAVID ANDERSON: One of the recent developments that I think is really encouraging is that communities are reaching out to our students and our residents and embracing them and exciting them about the opportunities to be able to come and work in communities around the province. Initiatives like the Lunenburg NOW . . .

THE CHAIR: Order, please. We'll now move on to the Liberal caucus and Minister Kousoulis.

HON. LABI KOUSOULIS: Thank you to my colleagues for allowing me to stay here today. It's actually my first committee so it's quite exciting for me because I've never had a chance or opportunity to experience committee work. Being at the Health Committee is very important not only to myself but to all the MLAs in the Legislature.

Dr. Anderson, thank you for being here today. I want to follow up on some of the questions that my colleagues asked, just to help us get some better insight into family medicine and specialty. I realize you're with the school and that you might not be the best person to answer this, but perhaps you could give your opinion: What is the ideal percentage that our family doctors out of all of our doctors graduating should make up for moving forward in the province to meet the needs of both specialists and family doctors?

DAVID ANDERSON: In my opinion, I think about a 50/50 ratio would be a very good target for us to achieve, both for graduates and for physicians in the province.

LABI KOUSOULIS: On that, do you feel we'll get to 50/50 by next year or the year after with the changes that have been made? When do you think we might see that? Do you track that within the school, when you anticipate that would happen?

DAVID ANDERSON: Our target is for 2022, when we're going to be 50/50 graduates of our medical school. The fact that we jumped from 25 per cent to 40 per cent in one year makes me guardedly optimistic that we may be there a bit sooner, but some of the other changes that I discussed earlier are going to take time, not to have effect, but they will be impacting first-year students who then will be three years before they'll be graduating. I think to see the true benefit of our efforts is going to take three years.

LABI KOUSOULIS: I wanted to move on to another topic. I think you can provide us great insight. I know it would cover the school as well, possibly, the college. I want to move on to international doctors. Perhaps you could give us some insight into why some international doctors can come into the province very easily and practise, but other ones we don't accept, and they have to almost jump through hoops. I'm assuming it's a difference within the education they receive at various medical schools by country. Then I'll follow up to that question.

DAVID ANDERSON: It is the provincial college of Nova Scotia that makes decisions around licensing physicians. It's not a university function. I just caution the committee that I have peripheral knowledge of this as a former department head that was involved in recruiting physicians and that sort of thing. There are others who can give you a more complete answer.

A major factor is around the credentialing of those physicians when they come to Canada, and where they graduated from internationally. There are some countries where there is what might be termed reciprocity around acceptance of the specialty designations in a country. For instance, the United Kingdom is one where the training program is quite closely aligned with what we have in Canada. Physicians who graduate through that rigorous model of training, their specialty credentials are generally accepted by the province. Those physicians have to pass examinations when they come to Nova Scotia and come to Canada. There are Canadian licensing examinations that they have to pass in order to receive a licence. One of those two factors may be impacting the ability of international graduates to receive positions here in the province.

LABI KOUSOULIS: With that, for other countries where we might not accept the level of education on par with what we have here in Canada - I know you had mentioned that some international doctors are accepted. I'm assuming they're accepted from countries that have equal reciprocity. For countries that don't have equal reciprocity, are there any steps that we could take in the province, or are there any other universities that offer a shorter program that you're aware of maybe in Canada that allows those doctors to come back, perhaps upgrade their skills in a shorter period of time, and then we can move them into a residency and have them practising in Canada?

DAVID ANDERSON: There is a program now that has been developed in collaboration with the College of Physicians and Surgeons and Doctors Nova Scotia which is called Practice Ready Assessment Program in the province. Dr. Gass was instrumental in developing that program for family physicians. I might ask if he could speak to that.

DAVID GASS: The program is aimed at those countries where the physicians who have trained and practised in those countries have a training program that is similar to ours, and the practice in the community is thought to be somewhat similar, but it's different enough that the college looks for assurance that they are ready to practise. We're working with the college to make sure that those who would basically meet their documentary requirements can come in and then move into a community practice where they will work in two different communities with two different preceptors who over a six-month period would evaluate how ready they are to actually practise well in Nova Scotia.

Obviously, in six months they also learn some skills and do some adaptations. If the preceptors judge at the end of the six months that they are ready to practise, then the college has indicated that they would be offering them licences as other graduates from the recognized countries would have, and they have to then write the other exams to confirm that ability, that certification in the country.

We're in the very early stages of that. We have the first group of international graduates who have written a therapeutics exam and are now looking at being assigned to communities for assessment. We hope that as that program evolves - we've planned for a capacity of entering 10 such international graduates each year, so it would be a significant addition to the physician supply in family medicine.

I know other departments are considering how they might do that in some of the Royal College specialty disciplines, but we're focusing on family to start with.

LABI KOUSOULIS: That's encouraging news. When do you think we might be up to the 10 family doctors per year? Is it within the next year or two or would it be a longer time frame to get up to that number?

DAVID GASS: We expect it will probably be two years. One of the limiting factors is being clear what the credential requirements of the college are in order to enter the assessment period. We're just kind of testing that market as we speak. We're also not well known yet among the international community so we hope that as the program has some success, that will increase. I'm a pathological optimist, so I would aim for two years, and we might take a bit longer. I'm less cautious than David, perhaps.

LABI KOUSOULIS: My other question - you spoke about the four international medical physicians that got residency here in the province. Could you tell us which countries they came from? I'm assuming that it was equal reciprocity in terms of training at the medical schools there.

DAVID ANDERSON: I can get the committee the information as to what countries they've come from. I don't have that with me right now.

LABI KOUSOULIS: As well, we spoke about our non-Dalhousie residency. Our retention rate in family medicine was approximately 50 per cent, which was a lot less than Dalhousie's. Have we done any analysis into why that would be? Does it fall solely that Dalhousie would have more Nova Scotia students who would want to remain in Nova Scotia, or would there be other factors for those resident students coming here? Do we even do any exit interviews upon graduation that we get more insight into this to help our numbers in the future and to increase them?

DAVID ANDERSON: I think that's a very good question. In our discussion with the residents, it is often the tie from home that will pull those residents back. If they have opportunities elsewhere, particularly from their home province or home city, they often take them.

I think as Dr. Gass has said, there is a calling home of Nova Scotians, so we do get physicians coming the other way. But once a non-Nova Scotian leaves the province to enter practice elsewhere, they're not likely to come back to Nova Scotia if they don't have family ties here.

[2:00 p.m.]

LABI KOUSOULIS: I'd like to thank you for all the answers, and I'll pass it on to my colleagues because I know they're eager to ask some questions as well. Thank you.

THE CHAIR: Mr. MacKay.

HUGH MACKAY: Thank you for a very enlightening program. It's interesting. I note when I was first considering getting into politics that there seemed to be quite an uproar about the wait times and so forth regarding orthopaedic surgeries in Nova Scotia. Now it seems that we have reached the turning point, the inflection point, and we're actually doing pretty well and trending probably middle of the pack in the country from previously being the worst.

I see some similarities here with the efforts you're making with your partners in government, with the Health Authorities, and the college and so forth that we're reaching a turning point in family physicians as well. No doubt in another five years, there'll be another thing that we're in here discussing.

One of the questions that I get asked a lot in my constituency is, why can't you add more seats to the residency programs? Why can't Dalhousie accept more? I would like to get some good credible statements I can use when I'm speaking to my constituents on that.

DAVID ANDERSON: As I have said earlier, this year we have added 25 new seats to our residency training programs. Those are 25 seats that will compound over time. The 15 specialty seats will be 75 new residents in those roles in five years' time. The 10 new family medicine positions is a two-year program, so that will be 20 a year starting next year. That is a very substantive increase in residency training capacity in the province. That is going to make a big difference in our production of family physicians and specialists with a focus on meeting community needs.

All of those family medicine training positions are outside of Halifax. Those 15 residency positions were designed to meet the need where we have gaps in specialty training positions in this province. That is a very substantive investment by the province that we are very grateful for. We very much look forward to seeing that implementation over the next five years.

HUGH MACKAY: Just as a follow-on to that, when I'm explaining this to my constituents, some of them will say, why don't you just double the number of seats? Why don't you triple the number of seats? Why don't we do this immediately? I know you have provided some narrative to that today, but could you go a little deeper to help me out?

DAVID ANDERSON: There are capacity issues in what we can do and what we can train. The 25 new residency positions is a huge undertaking for us in our Department of Family Medicine and in our specialty programs to take on this increased teaching

workload that our faculty will have to do. We are held to an incredibly rigorous accreditation standard both of our undergraduate and post-graduate education programs to ensure that there is no compromise of the training opportunities of existing medical students or existing residents by taking on this additional work. It will probably take us a year or two or three to see how well we are able to absorb this very large increase in undergraduate and residency training capacity, which is a great opportunity for us in the Faculty of Medicine - we're very excited by this.

When we have a chance to see how it goes, we will have ongoing discussions with our partners in the Health Authority, the Department of Health and Wellness, and the Department of Labour and Advanced Education to look at how we're doing, where our biggest training needs are, and where we need to course correct over time to have the biggest impact and make a difference to the health of the people of this province.

HUGH MACKAY: One of the things that you mentioned in your preamble is the need for inclusion, and that we were looking to try to bring in greater numbers of African Nova Scotians, Mi'kmaq, and so forth. Could you speak a little more to that, please?

DAVID ANDERSON: That has been a focus of our medical school, particularly over the last eight years. We do have what we would term an affirmative program, where if students from Nova Scotia of African descent or Indigenous students meet our minimal academic eligibility criteria, they are automatically accepted into our medical school program. There is no quota on this. We will take as many Nova Scotia students of African descent or Indigenous students who meet our eligibility criteria. Over the past eight years, we've had 30 Black Nova Scotian graduates and 20 Indigenous graduates in our province. We did not systematically track the number of Black Nova Scotian and Indigenous students prior to that, but historically over 50 years, we probably had less than 10 of each coming through the medical school. It is a sea change in focus in those particular areas.

Unfortunately, we have identified with our Mi'kmaq community that we have not been successful in that program in recruiting status Mi'kmaq students from Nova Scotia. We require a different, more concerted approach to address the Mi'kmaq population in particular. A major focus of our efforts right now is looking at making changes to enable us to recruit status Mi'kmaq students to our medical school.

HUGH MACKAY: I also appreciate, coming from, in my case, a semi-rural part of Nova Scotia, as my colleague the member for Pictou West has mentioned, we have an acute need for rural family physicians. I'm glad to hear of the steps that you're undertaking. Does Dalhousie work hand in hand with the NSHA on recruitment strategies and bringing those students who might be interested in seats at Dalhousie to work in rural areas? Do you work hand in hand with the NSHA on that?

DAVID ANDERSON: I would say yes. I might ask Dr. Gass to speak about that, being more directly involved with the family medicine resident recruitment.

DAVID GASS: Briefly, we've increased our connection with the NSHA recruiters in a strong way with each of our sites so that all the residents in those sites have a chance to be approached and be made aware of opportunities that are existing in those communities and in other communities. An issue for recruitment sometimes is . . .

THE CHAIR: Order, please. That concludes our time with the Liberal caucus. We'll now move to three rounds of 10 minutes. No one caught that I cut off five minutes from the NDP's time, so I will correct that by going 10 minutes to the PCs, 15 minutes to the NDP, and then back to the Liberal caucus for 10 minutes. I hope that's satisfactory to everyone. Ms. Adams.

BARBARA ADAMS: I'm going to turn things over to questions about income for physicians in the province. The Nova Scotia physician resource plan said that we need 1,000 new doctors by 2026 - 500 family medicine and 500 specialists. We were hearing numbers from you in terms of how many Nova Scotian graduates were turning towards family medicine.

I want to make it clear for those who are watching that it's your job to train really highly trained physicians. You're doing an excellent job. I'm a former Dalhousie grad in health care. I think it's really important for people to understand that it's your job to train physicians, but it's the job of the Department of Health and Wellness, through funding and other initiatives, to ensure that we have enough physicians in the province. The sort of elephant in the room is the fact that the number one reason I hear most quoted as to why medical students aren't staying here or coming back is that they're frankly not paid enough.

We know that Nova Scotia physicians are paid the lowest salary in the country by far. Newfoundland is next at about 4 per cent more than us, all the way up to Ontario, which is 40 per cent higher. I wanted to remind everyone that Alberta is now - the nation's highest-paid physicians get $380,000 a year, and they don't have the same recruitment issues. I would like you to comment on the fact that our physicians in this province are the lowest paid and how you believe that impacts medical students' choices.

We can train them and provide them with teaching opportunities, and we can give family doctors pay to actually come into the universities to teach and fund them to do so, which is fabulous. But if there's no financial incentive to stay here, then the worry is that we have a whole bunch of highly trained Dalhousie graduates who are leaving to go elsewhere. I'm wondering if you can comment on the wage disparity and how you think that impacts students' willingness to stay in Nova Scotia.

DAVID ANDERSON: There are many factors in decisions that physicians make around recruitment and retention. Money is one of those factors, and there are many others. Quality of life and opportunity to practise the type of medical care that one was trained to do and is passionate to do are other factors. I think the success around the recruitment and retention of Dalhousie graduates, particularly focusing on family medicine, which is the greatest area of need in the province, has been pretty impressive over the past five years. Our strategy of increasing the number of medical school seats, increasing the number of residency positions to recruit and retain physicians in this province has been shown to be very successful.

I think there are a number of factors involved in recruitment and retention, but to have excellent positions in communities where these residents have had the experience of being able to be trained and embraced by those communities are very important factors in their decisions to stay in the province. Over 80 per cent of our Dalhousie grads trained in family medicine positions are staying in the province.

BARBARA ADAMS: I was reminded of a comment that had been made earlier by another member that we were in the middle of the pack with respect to orthopaedic wait times; frankly, that's not something that I believe is the current belief. As a physiotherapist working in that industry for years, our wait times for orthopaedic surgeries are still the worst, with the exception of if you fracture a hip.

Nova Scotians in this province, between 50,000 and 100,000, who are waiting for a family doctor - that number has not significantly changed over the past five years. Despite all of these initiatives and changes that are occurring, there are still far too many Nova Scotians without a family doctor, in particular in rural areas like Yarmouth and Cape Breton. I'm wondering, with the change in the announcement for new seats with a significant rural focus, can you tell me how many of the 16 seats that were announced are going to be reserved for students coming from rural Nova Scotia? We know that when you come from a rural community, you're more likely to go back.

DAVID ANDERSON: We are going to be using the 16 new seats to balance the number of students being admitted to medical school between urban and rural communities to make sure that our student numbers are aligned with population-based numbers of our communities. Potentially all 16 of them may be focused on recruiting community graduates, depending on the numbers of admitted students for that particular year.

BARBARA ADAMS: One of the things that's currently happening is we have moved from the fee-for-service and the alternative payment plan. Now we're waiting for the blended model that's coming. Between that change of a blended model of payment, the tax changes that happened federally that further cut back on a physician's take-home pay and the changes with collaborative practices so that there are now clinical nurse practitioners who are taking over some of the workload, have you heard the concerns of medical students about how they may be paid in the future in this province?

[2:15 p.m.]

Right at the moment, they are still waiting for a contract to be signed. Are you hearing concerns from medical students about the pay structure and how that's happening in this province and the fairness across all the regions in Nova Scotia?

DAVID ANDERSON: You have to appreciate that medical students are years away from where those are going to become issues for them, so it's not a top-of-mind discussion amongst medical students about how they're going to be paid when they enter practice. Ms. Martin asked earlier about the debt load that students are carrying when they graduate from medical school, which is certainly a concern for them, and being able to manage their debt and get rid of that in a timely manner is their concern.

BARBARA ADAMS: As a former health student, I knew what the pay structure was for every province across the country. It certainly impacted my choice of where I wanted to work, so I think that's an issue for all medical students.

The respect family physicians in this province get is sometimes lacking, and I think that people fail to appreciate that they are a medical specialty in their own right. So I'm delighted that the family physicians are now being paid to help teach because I think that shows them that respect. I hope that is expanded across the province rurally.

I'm wondering how your department works with the Department of Health and Wellness to track the gaps in services across the province - how the gaps have changed over the last few years in terms of making sure that there are sufficient physicians who are in family practice, versus specialists, versus hospitalists, versus the researchers, versus the academics. I'm just wondering how you're tracking those gaps in services.

DAVID ANDERSON: First, I'd like to say that I completely agree with your first comment that family physicians are an incredibly valuable part of the health system in the province. As primary care providers, they are the backbone of health care in this province. They are specialists and they are special in family medicine, so I completely agree.

With the shortages of family physicians and particularly with the number of patients that do not have a family physician, every physician in the province appreciates the value of having family doctors, and that in part relates to our commitment in training more family doctors in our programs.

We have a committee that consists of people from our shop - our residency training directors - who meet with Department of Health and Wellness officials and Department of Labour and Advanced Education officials, and those from the Health Authority, to talk about where we need residents, where we need to make course corrections . . .

THE CHAIR: Order, please. Our time has elapsed for the PC caucus, and we will now move on to the NDP caucus for 15 minutes. Ms. Leblanc.

SUSAN LEBLANC: Thank you for being here. I'm enjoying this discussion very much and I was particularly interested in your response to somebody's question about your consultation with the students and their responses to why maybe they weren't going into family practice specialties. I appreciate all of those answers and they make sense to me.

I'm sorry, I didn't hear your question regarding family practice versus speciality, but I was going to ask, has there ever been consideration of words and titles? Words are powerful and I know that when I was a young junior high/high school student thinking about wanting to be a doctor at one time in my life - that was a long time ago - I always heard about specialists and then what we called family doctors or general practitioners, and they're very separate things. I'm even doing this - like there's this and there's this, but they are this. Hansard is not going to understand that. (Laughter) I was making a motion to explain that they should be on the same level.

I wonder if there has ever been any consideration of changing the language around family practice physicians versus specialists. Is there a way to rid our lexicon of the word "specialist" in place of something else or to include family practice specialist or something like that? Is that ever a discussion that's had?

DAVID ANDERSON: We just had that discussion yesterday in preparation for the meeting with you today. Like Ms. Adams' question, family physicians are specialists, and they are special. Some family physicians do additional training after family medicine to focus on a particular area. We absolutely need these physicians to ensure that our health care system works well. I think that any consideration that there's a value distinction by calling one group family medicine and another group specialists, I completely concur. It's a problem. Certainly with our students, we want to give them that message that family physicians are very special, and they are specialists, and this is a career that is absolutely worth pursuing. The most important need that we have in society right now is to have more of our graduates going into family medicine.

Again, I might ask Dr. Gass to comment because I know he feels passionate about this as well.

DAVID GASS: It is an important issue, and it has been talked about. It is agreed at the national level that the College of Family Physicians consider their graduates, the people they certify, as specialists in family medicine. The biggest language challenge is to turn that around and talk about family physicians and other specialists. That would be the simplest way we could do that.

I think the important thing, language aside, is that in the last few years, it has also become apparent that more and more people have appreciated that family physicians are a key element in the health care system, along with specialists from other disciplines. It has

been encouraging to hear that reflected from our colleagues as they experience the difficulty of the shortage of family physicians and the impact on their specialized practices. It is important, and it is relevant. It's important in attracting students so that they see this as a career that's as central to the health care system as any other discipline.

SUSAN LEBLANC: I was also wondering - I understand in Nova Scotia we have a real need and a real concern around family practice in rural areas. I'm glad to know that a lot of the residency programs are focusing on rural areas. I come from a constituency that is very urban. There's urban and then there's urban. In my riding, we have an extremely dense core of people who are in extreme need. We have very high social and material deprivation. We have high levels of mental health and addictions issues. I could continue on. We have a huge amount of people in core housing need, for instance, or precarious housing, lots of issues around homelessness. I'm wondering if there's anything in the specialty of family medicine that focuses on inner-city urban core issues particularly. Is that a focus for Dalhousie?

DAVID ANDERSON: I think that is a very important area. I would ask Dr. Gass to comment on that if he would.

DAVID GASS: Historically, the focus on the need for family physicians has been rural. In the last few years, it has become apparent that there are also urban needs. They may look somewhat different. They may be focused on the social determinants of health that you identified. In our program, we have a significant urban-based part of the program. That program allows us to focus on some of the issues around how we identify people who are housing- or income-challenged and then how our program responds differently to them. That is a curriculum discussion with us as well as an operational discussion for the clinics that we manage.

If we were to look at expansion, as we increase the needs, we see where we are short. It would seem that there are some urban communities that, probably equally with other rural communities, would be on the list of where we might expand and support practices that address those particular issues.

We have in our program - and some folks are attracted to the Halifax component of it because they are interested in addressing the challenging urban health issues that primary care and family medicine experience, so it's very much on our radar. It's a curriculum issue. It is a discussion about - as we anticipate potentially increasing further - whether a focused urban program perhaps on the other side of the harbour would be an important place to be. That does then highlight the challenge of finding the teachers and finding the settings and the team-based care that match the community's needs well, which is where those kinds of learning experiences should be.

That is also an active discussion with the Health Authority where we recognize that our residents are hoping to work in team-based settings as they graduate. So the more we expand and find those and develop those, and include them as teaching sites, the more successful we'll be.

SUSAN LEBLANC: In the #DalMedForward strategic plan from 2016 to 2020, under focus area four, you've stated a goal of enhancing the health of Maritimers through excellence in education. You say you'll know that you're succeeding in the long run or the longer run when Dal learners across the continuum have accelerated the "transformation needed in health care delivery." Can you talk about what that transformation is and what the system is now and what it should look like in the future, in your view?

DAVID ANDERSON: One of the important areas around system transformation is leadership, and what we promote in our graduates is that they be leaders in health care in addition to being excellent practitioners. So to be taking leadership roles - whether they be within clinics, within systems, or at a provincial level - is something that we'd like our graduates to aspire to do at an early stage of their career, not just saying after 20 or 30 years of practice, you're good enough now that you should be moving up and becoming an administrator. Getting our students and our graduates engaged at system problem solving, in addition to providing excellent care to individual patients, is part of that transformation.

SUSAN LEBLANC: My question written here is, what is the role of the medical school in that transformation? Are you actively thinking about how you approach that with students right now in the curriculum planning?

DAVID ANDERSON: Absolutely. We're looking at the role of the students in leadership, the role in teams. A lot of focus in medical school now is on interprofessional education, how do physicians work with health care providers, nurses, physiotherapists, occupational therapists, social workers, pharmacy, et cetera, in delivering team-based care?

In addition, it's providing experiences in the communities; our students being able to see what the issues and challenges are in rural areas is another very important facet to this. We also have what we term service learning programs. All of our students have the opportunity to participate in programs that often deal with socially disadvantaged people in our region. One clinic is called HOPES, which is an interprofessional, student-led clinic, focusing on the care of disadvantaged populations.

There are many other programs where our students perform what would be considered volunteer work, although it's part of their curriculum to work with disadvantaged people, addressing social determinants of health, addressing literacy issues, volunteering in other ways to contribute to society. These are all very important parts of the fabric of the medical school as we look to create the leaders of health and the health system of tomorrow.

[2:30 p.m.]

DAVID GASS: That's an excellent question. I would just like to respond that in the family medicine program, in sites throughout Nova Scotia and throughout the Maritimes, our residents are encouraged to look for a community need or a community charity that they can contribute to as members of that community. In recognition that the community is supporting their education, they should give thought to giving back. The residents have been outstanding in their interest in that and in their engagement with the communities. One of the side effects of that or the outputs is that communities are also recognizing the residents as a major contributor within their environments, stepping up and encouraging and welcoming them and returning that support. I can say that the to and fro of engagement with the communities is a key recruiting action to good effect.

SUSAN LEBLANC: Can you talk a little bit about the Tier 2 Canada Research Chair in Primary Care, what the status of it is? Can you talk about what kind of research will be conducted and how that research will interface with the Nova Scotia health care system?

DAVID ANDERSON: Maybe I can start, and Dr. Gass can also comment. That will be a research chair who will be performing evaluation of primary care delivery in this province. We look to see that position being very closely integrated with the Nova Scotia Health Authority in particular and working at the evaluation of the various models of delivery of primary care that we're doing in this province. We want to know what works well and do more of it. What is not working so well, we want to replace with a better system. That is a very important strategic research position that we're moving through the recruitment process at this time.

I would just ask David to comment as well.

DAVID GASS: This is an exciting development for our research unit in the department of family medicine. It has had as its focus to date looking at the health system and its impact on outcomes and the things that determine the effectiveness of primary care interventions, including family physicians. The Canada Research Chair would enable us to strengthen that ability to get actual data and information about the effects of how we operate within the system, analyze that critically, and then apply it in partnership with the Health Authority to future directions as the move towards collaborative team-based care evolves. This is an exciting opportunity, and it is the focus of the direction for our research unit in the department, of which we're quite proud.

SUSAN LEBLANC: We're often hearing that medical graduates have different priorities, that the new generation has different priorities than their forebearers. Can you speak to what you're hearing from medical students about the expectations about practice when they graduate and how you feel that the school or the government should be responding to these values?

THE CHAIR: Dr. Anderson, four seconds.

DAVID ANDERSON: Yes is the answer.

THE CHAIR: That concludes the time for the NDP caucus. We'll now move on to the Liberal caucus. Ms. Miller.

MARGARET MILLER: Thank you to both Dr. Anderson and Dr. Gass for being here today. During your comments and the answers that I have been hearing to questions, sometimes I want to sit here and applaud, although it's not appropriate in this Chamber. It really seems that we have a new path, that things are really looking up in Nova Scotia. I know that sometimes we hear so much negativity, and I find that sometimes that's self-fulfilling. When you start talking a down game, that becomes the narrative when we should be looking at the positive. I, too, am an optimist, so I'm trying to look at the positive all the time. Thank you for that.

My first question is, how many students apply every year to Dalhousie Medical School compared to - what percentage actually get in compared to who applies?

DAVID ANDERSON: It varies from year to year, but over 1,000 applicants would be a typical year of students who would apply. Those are students across the country and even internationally - receive applicants who are not eligible to come to Dal.

If we look at Nova Scotians that apply to medical school, last year about 250 Nova Scotians applied to get into Dalhousie Medical School. If we just walk through what happened to those applications, about 150 of those 250 met our minimal eligibility criteria. They had an adequate grade point average, they had an adequate score on the standardized test called the MCAT score, and we do another standardized test that looks for traits of empathy, collegiality, collaboration, which they also have to take.

So 150 students got through that phase and they were offered an interview. All of the students that meet our minimal eligibility criteria from the province get an interview. One hundred and twenty students passed through the interview process and then were eligible for admission. The Nova Scotian students of African descent were given admission. Students of Indigenous background were given admission, and then there was a ranking of the remainder of the students and the top ones got into medical school.

If you just sort of do the math, about 50 per cent of students who have the minimal academic requirements actually get into medical school. We'll see what the impact is of these additional 16 seats and it possibly will mean more students will apply. We make the point that it is very achievable for Nova Scotian students to get into Dalhousie Medical School and one in two that are academically eligible are offered a seat. Many people have a myth that it's one in 100 or it's impossible to get into medical school. That is just not the case. We strongly encourage students who are interested, to work hard and to apply when they have the opportunity. We'd love to have them in our campus.

MARGARET MILLER: Thank you, that's really good to know, because my perception was a little bit off on that as well. When you're talking about the internationally trained students that are coming in or applying to come in for their third and fourth years - possibly they had applied to Dalhousie and didn't get in and maybe went to Saba or went somewhere else - how many of those students actually applied to get into that small window of acceptance there?

DAVID ANDERSON: I'm sorry, I don't have those numbers off the top of my head, but I can get those and provide them to the committee.

MARGARET MILLER: Can you tell me what the GPA is for students? What is the requirement for students who want to come into medical school?

DAVID ANDERSON: The minimal GPA for Nova Scotian applicants is 3.4. That is somewhere between a B^+ and an A^- if you're using those metrics, or around the 80^{th} percentile, if you're using a numerical score.

MARGARET MILLER: Just shortly - more of a comment than anything - we were talking about international doctors coming to Nova Scotia on recruitment. I think the last figures are that 42 have applied on our immigration stream. So if those doctors all enter our system through however way they do it, that will certainly be in addition to that.

I want to thank you so much. It has been very enlightening today. Regretfully, I have to pass this on to my colleague.

THE CHAIR: We will move on now to Mr. Horne.

BILL HORNE: I've been listening here very intently. It seems to be a number one issue for Nova Scotians - having a doctor.

Not until the second last speaker mentioned collaborative care, that word hadn't come up all day. I was wondering if you could go a little bit into where the university stands on collaborative care. You may call it something else, and I think you have - inter-specialists and so on. I think collaborative care appears to me to be the most operative way to operate now. There are 17 new clinics coming up that seem to go by that collaborative care. Really it wasn't something that we had in the past, although there was probably something close, where you have many different disciplines involved in a clinic. I wonder if you can comment.

DAVID ANDERSON: As I said earlier, it is certainly how we're training our students in looking at interprofessional opportunities and looking at working in teams and functioning in teams. As they move into residency, that is the same training paradigm. For many, it's what they're expecting to do when they graduate. It's how they trained. It's how they want to work. Again, I would like Dr. Gass to comment, as this is near and dear to his heart as the head of family medicine.

DAVID GASS: This is a key element of the future as we see it. It's clear that our students and residents are expecting to work collaboratively with other providers in providing primary care. In fact, many of our settings already are team-based, where the residents are learning. Our goal is to take that a step further and make sure that there are learners from all disciplines practising in the same environment so that you have that peer interaction occurring at the learning level as well as at the service and care delivery level.

We're actively working with the Faculty of Health and particularly the school of nursing to achieve that for nurse practitioners and family practice nurses along with our family physicians. We're working with the Health Authority as they establish collaborative primary care teams to encourage them to make sure that as they develop those, they're anticipating that they will be teaching teams, that they will have space for learners of all disciplines, have the kind of technology that learners expect to be available now to help them with their learning, and we have the teaching support for the other providers who can act as teachers, physiotherapists, nurses, nurse practitioners, or any of the variety of health professionals who could reasonably be part of a primary care team.

BILL HORNE: A quick question on the flexibility of government to work on new strains of training for our new medical students and so on. Do you see the flexibility in government to be able to help increase the number of doctors in Nova Scotia? Or are we out of that area, and it's totally in the Dalhousie Medical School?

DAVID ANDERSON: I would just say it is a necessary collaboration. The medical school needs to work with the Health Authorities, needs to work with Doctors Nova Scotia, and needs to work with government. We have the structures in place to review that on a regular basis and make sure that our graduates are meeting the needs of society and that we have our training program and numbers right. We do course correct if we have concerns and we need to place more emphasis in one area than in another.

David, I'm not sure if you have an additional comment.

DAVID GASS: I think that matching our training capacity to community needs is the key discussion that's going on. I would say that in our experience, both the Health Authority and the Department of Health and Wellness have been willing to enter those discussions and are interested in understanding the challenges and the implications of making those kinds of changes and making sure we have the right numbers. That's an ongoing discussion.

THE CHAIR: Order, please. That concludes our time for questions. I would like to thank all members for their questions today and our witnesses for their responses. I would like to give our witnesses one or two minutes if they would like to make any closing remarks. Dr. Anderson.

DAVID ANDERSON: I would like to sincerely thank this legislative committee for asking us to come and speak with you today. We think it is really wonderful that you recognize that the Dalhousie Medical School in particular does have an important role in health and health care delivery in our province. We are very committed to be working with our partner organizations to make this health care system work. I want to leave members of the committee with the assurances that we meet regularly and effectively with our partners in the Health Authorities and within government to work to ensure that decisions that are made are in the best interests of the people of the Province of Nova Scotia.

[2:45 p.m.]

I want to thank my colleague, Dr. Gass, for coming and helping me here today. I think his insights were particularly important, given the importance of the specialty of family medicine in our province. Thank you very much.

THE CHAIR: On behalf of the committee, thank you very much for coming and sharing your knowledge and wisdom. You are important partners to all of us here in this province to be working with young Nova Scotians and other medical students from far and wide, and you're an important part of the solutions to health care that we're all working together to solve. Again, I want to thank you. You may now be excused. We have a little bit of committee business to get to.

Members of the committee, we have a couple of pieces of correspondence to deal with. We have a letter from Krista Grant from the NSHA in response to requests for information on February 2nd. It has been recently circulated. Any comments? Agreed to receive? Everyone is in agreement.

As well, you've got a thick document here, which is a response to follow-up questions from the meeting of May 14th. There is a lot of information there. Comments on this? Ms. Martin.

TAMMY MARTIN: I would just like to state for the record that this is not the information that we requested. We will go after it in another way, but there is clearly misinformation coming from that department on who was part of the original committee.

THE CHAIR: Do you want to clarify this with the clerk after the meeting or is it something we should get into now?

TAMMY MARTIN: No, that's fine.

THE CHAIR: Are there any other comments to this information? The next item on the agenda is with respect to a difference of opinion on what one member stated and what another member interpreted from that statement. I understand Ms. Miller has a comment with respect to that. A copy of Hansard from June 20th is there. Ms. Miller.

MARGARET MILLER: I'm very pleased to be able to address the narrative from the last Health Committee on June 20th. On Page 9 of the printout, Ms. MacFarlane says, "Is it fair to say at this point - just a simple yes or no answer - that none of the 35 recommendations today have been considered for being implemented within, let's say, over the summer or any time quickly?" Further to that, she also stated later on, "It's somewhat disappointing to see that - my understanding anyway, is that none of them have been implemented at this point."

My response to that said, "I found it interesting that the PC caucus has suggested that the government move forward with all your recommendations. (Interruptions) I agree that a lot of the recommendations you had made are really great, but usually the narrative is extreme caution . . ." and, I would question - it says on here, "collaboration," but I believe it should have been "consultation." So I found that interesting. I will retract the word "all" from my words, but I do reiterate my observation that it does seem interesting that moving forward with changes within six weeks of the report's presentation is unusual in a climate where changes are only considered after due consideration and careful consultation.

THE CHAIR: Are there any other comments? Ms. MacFarlane.

KARLA MACFARLANE: I want to thank my colleague for addressing this issue. I think the environment that we are in as politicians - we're all hyper-aware of always being accused of saying something that we didn't. My point was, as we look at Page 22 and what was said verbatim, "My colleagues here - I found it interesting that the PC caucus has suggested that the government move forward with all your recommendations . . ." as she indicated earlier. I think it's important that when we have constituents and Nova Scotians watching us here, that they completely understand what our intentions are, and there was nowhere in the date of this meeting that I indicated or suggested that all recommendations be implemented and move forward.

I accept that she will remove "all" and again, I think we always have to be very careful in assuming that we indicate to the public, since this is in the public domain, someone saying something that they didn't say.

THE CHAIR: That concludes this issue.

Our next meeting will be on Tuesday, September 10th from 1:00 p.m. until 3:00 p.m. The witnesses will be the Department of Health and Wellness and the Nova Scotia Health Authority regarding collaborative practice teams and doctor recruitment, and agenda setting. Agenda setting will also form part of that meeting, so we'll ask each caucus to forward proposed topics to the clerk, Judy Kavanagh, by August 27th.

With that, the meeting is adjourned. Thank you.

[The committee adjourned at 2:51 p.m.]