HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, October 13, 2020

LEGISLATIVE CHAMBER

Ongoing Doctor Shortage

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STANDING COMMITTEE ON HEALTH

Suzanne Lohnes-Croft (Chair)
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Hon. Margaret Miller
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Barbara Adams
Colton LeBlanc
Susan Leblanc
Kendra Coombes

[Bill Horne replaced Hon. Margaret Miller]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Doctors Nova Scotia

Dr. Robyn MacQuarrie, President
Nancy MacCready-Williams, CEO
Dr. Amanda MacDonald
Dr. Leisha Hawker

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, OCTOBER 13, 2020

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Suzanne Lohnes-Croft

VICE-CHAIR
Keith Irving

THE CHAIR: Order. I call this meeting of the Standing Committee on Health to order. Today is Tuesday, October 13, 2020. My name is Suzanne Lohnes-Croft and I'm the MLA for Lunenburg.

Today we will hear from Doctors Nova Scotia regarding the ongoing doctor shortage. After that, we will set an agenda of topics and witnesses for future meetings. Question period will probably close around 2:50 p.m., just so that you keep that in mind.

Please set your phones on silent or vibrate, and if we should have an emergency, please exit through the back door, walk down the hill to Hollis Street, and meet at the courtyard of the Art Gallery of Nova Scotia.

Please keep your masks on during the meeting unless you are speaking, but if you're doing a back-and-forth with someone you can keep your mask off; you don't have to keep re-masking. If you're the person asking a question, while you're receiving your answer, you can leave your mask off.

To maintain as much physical distance as possible, we ask that you remain in your seat if at all possible, and we will take a 15-minute break, if you're all in agreement, at 2:00 o'clock, and then resume the meeting and we will have the meeting end at 3:15 p.m. Are we all in agreement to that? We have consent by everyone.

To remind, when you leave the Chamber, you are to use the doors to the anterooms and walk around, and then go over and take the stairway by the elevator and out to the back door to the street, or you can go down the flight and go behind the stairs and out the back door.

We will start with our introductions, beginning with the Liberal caucus.

[The committee members and witnesses introduced themselves.]

THE CHAIR: Dr. MacQuarrie, we'll have you start the introductions and then you can just go into your opening remarks.

DR. ROBYN MACQUARRIE: I'm Dr. Robyn MacQuarrie, and I'm President of Doctors Nova Scotia. It's a pleasure to be here today.

I'm going to pass it over to Nancy who's actually going to start off our comments.

NANCY MACCREADY-WILLIAMS: Hello, I'm Nancy MacCready-Williams, CEO of Doctors Nova Scotia. It's a pleasure to be here today. I'd like to introduce my two colleagues: to my immediate right is Dr. Amanda MacDonald and to my far right, Dr. Leisha Hawker - both family physicians in this province.

As you know, physician recruitment is a national issue, and Nova Scotia is not immune. Doctors are aging. In fact, over 50 per cent of our members of practising physicians in Nova Scotia are over the age of 50. More than 47,000 Nova Scotians are without a family doctor.

While our province is working hard to recruit physicians, Doctors Nova Scotia is also working to improve the chances to recruit in this extremely competitive environment, so that Nova Scotia is a welcoming place where physicians choose to practise.

As the negotiator of physician compensation in Nova Scotia, we work to ensure that Nova Scotia physicians are fairly and competitively compensated. In our last negotiations with the province, we began advocating specifically for competitive compensation at the Maritime and Atlantic Canadian level such that Nova Scotia can compete with our neighbouring provinces. Often, we find ourselves competing for the same resources: physicians graduating from Dalhousie Medical School.

We also identified the need to engage physicians and health system change to improve their work environment by reducing red tape at a time when they were not feeling supported and to strengthen their right to representation. Working closely with government, we now have negotiated new contracts that begin to recognize the value of Nova Scotia's doctors and begin to help stabilize some of the most vital services in our health care system so that patients have better access to the care they need, when they need it.

We paid particular attention to specialties that were facing significant recruitment challenges - family doctors who provide comprehensive care such as through office visits, emergency medicine, in-patient care, nursing homes, obstetrics, and maternal care. Those family physicians saw significant increase in pay, bringing their compensation to the top in Atlantic Canada.

Community-based hospital in-patient care has been shored up and there's an investment to pilot a new blended capitation payment model for family physicians. These will all help to stabilize Nova Scotia's family physician workforce and significantly improve our opportunity to recruit. Additionally, specialists who practice emergency medicine, obstetrics and gynecology, psychiatry, and anesthesiology saw an increase under these contracts that improve the Province's ability to recruit and retain these essential services, as well.

Government has made a commitment to support succession planning, to reduce administrative red tape, and to focus first-time audits on education. Doctors Nova Scotia has secured physicians' right to representation in all aspects of their contract negotiations, including not only compensation, but also the services that can be required of physicians in exchange for that compensation through a memorandum of agreement between Doctors Nova Scotia, the government, and the two health authorities.

Nova Scotia is a national leader in the distributed model of medical education with government, Dalhousie, and the health authorities making great strides with medical education. We have opened up additional undergraduate seats to boost diversity and new residency programs for family medicine and for specialties, which train learners in rural communities.

We now have two Longitudinal Integrated Clerkship programs in the province. These are wonderful investments and we must do all we can to ensure that graduates of these programs stay and practise in Nova Scotia. We are incredibly fortunate to have a medical school in this province, and we need to work collaboratively to reap the rewards of these investments.

We believe the contracts signal a new level of support for physicians and will help make Nova Scotia a go-to destination for physician talent. We are in a national competition to recruit physicians. We've made some great investments through the contracts in medical education and in engaging communities in recruiting, but we cannot be complacent. We must be committed to working together. There is much to be done, and Doctors Nova Scotia is anxious to be a part of this work.

I'll now hand off to Dr. MacQuarrie.

THE CHAIR: Dr. MacQuarrie.

ROBYN MACQUARRIE: Thank you. I have specific plans to keep my comments to a certain period of time, but taking my mask off is incentivizing me to talk longer. (Laughter)

The COVID-19 pandemic tested that commitment that Nancy discussed, and government responded and delivered. It has been a challenging time for doctors across our province as we adapt our practices, care for our patients who are more afraid than they've ever been, and protect ourselves and our families from the risks of COVID-19. I'm incredibly proud of my colleagues from Yarmouth to Sydney and everywhere in between who stepped up in the face of the great uncertainty and fear of what to do best, and often that information of what to do best was changing on a daily basis.

Nancy talked about the many great investments that were made recently in our contract. These investments were made under the specific goals of fortifying recruitment and retention. As somebody who works in the community, one doctor is a significant percentage of my work cohort, so it's really important that we work on not only recruiting, but also retaining doctors in our province, particularly in our communities.

I want just to focus on one specific investment. It's an investment that's topical across the country and it's expected to be an investment made in provinces across the country. Virtual care is one of the cornerstones that allowed us to care for patients during the first wave of the pandemic. Our province supported an agreement that was made during the pandemic to enable physicians to bill an office visit for virtual care visits by telephone or video conference.

Supporting doctors to work in this way protects the patients from having to leave their homes and sit in a clinic where they could be in contact with someone with COVID-19. The public also has a great fear about being in crowded spaces right now and are doing their best to adhere to the Public Health guidelines that are recommended for them. We certainly don't want seeing their doctor to be where they have to make an exception.

Recently, virtual care codes were extended to the end of this year, which is great news for both doctors and their patients as we anticipate the second wave. The extension provides doctors the certainty that we need to book our clinics for the next few months, knowing that some of these appointments can be virtual. I say some of these appointments, because obviously a part of medicine is putting your hands on somebody, examining them, and really assessing what their needs are.

We have been able to reserve our in-person appointments for patients who really need it, and also ensure the Public Health guidelines of social distancing are followed. Virtual care does not replace the need for in-person care, but it can complement a patient's care and provide access for all patients.

Beyond the pandemic, virtual care is a way to make it more convenient for patients to get the care they need. Public polling shows 95 per cent of patients who received virtual

care during COVID-19 were completely or mostly satisfied with that experience. I think most people would take a 95 per cent approval rating in this room. (Laughter)

Through virtual care, doctors can provide advice on changes to care plans; they can triage new health concerns; they can counsel people with anxiety; they can refer patients to specialists; and specialists can review test results and determine care plans. As a specialist myself - I'm a surgeon, I can't do that virtually yet. Maybe if someone wants to invest in a big robot we can talk about that. (Laughter) However it has allowed me to provide reproductive access during COVID in a way that would have drastically changed the lives of women in this province if they were not able to receive reproductive care.

That is one of the ways in which being able to do virtual care has allowed me to really direct the needs of the patients. I work in a community in which not everybody provides all different services, and it was important to me that the patients in my community weren't left alone, even as I was following the guidelines.

Other provinces have also implemented virtual care as a permanent tool when an in-person appointment is not needed. As such, we have improved Nova Scotia's ability to attract and retain physicians. We must keep up with the other provinces, so this is focusing a little bit more on that retention piece. Virtual care is here to stay, because the patients want it to be here to stay, and it's important that we are competitive with the other provinces in a way to do so.

It must be an option for patients to see a doctor by telephone or video conference appointment. Every encounter doesn't necessarily require an in-office visit. We need to fully leverage both virtual visits and secure methods to be able to email and text patients as well.

We can bring our health care system into the future to deliver safe and quality care, improved access, and convenience for our patients. We're advocating to continue the support and make virtual care a part of the way care is delivered in our province on a permanent basis.

I'm going to hand off now to Drs. Amanda MacDonald and Leisha Hawker, and they're going to share their experiences with you.

THE CHAIR: Dr. MacDonald.

DR. AMANDA MACDONALD: I'm a family physician that co-founded Windsor Collaborative Practice. I also work in long-term care and as an aid provider, I'm a network lead with Nova Scotia Health and sit on the Doctors Nova Scotia Board of Directors.

When I started my practice, it was quite varied. I was doing hospitalist, long-term care, clinic, and working in emergency departments throughout the province, and I loved the variety. Further, having trained in a rural longitudinal-based residency program in the

Annapolis Valley, I felt competent to do that breadth of work. However, it was a monthly scheduling juggernaut. I was managing six different schedules that were all independently made that had little flexibility within them. If an event or illness came, the whole stack of cards came down.

[1:15 p.m.]

When I started my family, I didn't want to continue working within that scheduling matrix, so I narrowed my focus. In doing so, I kept the pieces where I had more control. Control the schedule, control to modify, and control to make the work fit around my life and not the other way around. I miss the variety of medicine that I was providing, but my job satisfaction remains really high. I think that's because I've instilled a work-life balance.

The challenge of practising comprehensively is that it's based on the premise that the physician is available Monday to Friday, 8:00 a.m. to 5:00 p.m., after hours, and weekends. There isn't much flexibility for different work arrangements. It's often very much all or nothing, unless you're doing a solely clinic-based practice.

As equal numbers of women to men are now practising medicine, we need to have increased consideration for the fact that those who are phenotypically female may need time off to have children and flexibility following in that. Parents within my generation, regardless of gender, are very involved and hands-on with their families, and that takes time.

Too often, physicians are forced into work styles that don't align with their personal lives. Creating flexibility is one of the biggest opportunities for us to recruit and retain physicians in Nova Scotia. Allowing physicians to balance aggressive schedules with family commitments lets them provide comprehensive medicine consistently while reducing burnout and improving community access to the care that they need.

It's time to shake up how work is actually organized in our province. That requires challenging and emotional conversations to examine which pieces of care delivery should remain the same and which pieces should be reorganized. Shaking up the system also means supporting collaborative care, not competitive care. We need to look at how care is delivered holistically as a system and adjust payment models to better reflect comprehensive and quality care rather than just volume-driven metrics.

Technology has a huge role to play in this. By increasing patient access to care and allowing physicians to maximize their ability to have high output of quality work, we have an opportunity to create a really great system that improves access to care, is desirable to work in, and is cost neutral to current spending.

Thank you. Now, Dr. Leisha Hawker.

DR. LEISHA HAWKER: Thank you, Dr. MacDonald. I've worked at the North End Community Health Centre just down the road, providing primary care for the past seven years. I'm also an addictions physician at the Regency Park Clinic and a family physician for the Newcomer Health Clinic, where I provide primary care to newly arrived refugee claimants and refugees. In my first five years, I did locum work in remote fly-in communities of the Northwest Territories.

I've served on the boards of the Nova Scotia College of Family Physicians and Doctors Nova Scotia. I am currently co-chair of Doctors Nova Scotia's E-health Committee, a group of 10 of my peers with a single mission in mind: creating a future in which Nova Scotian physicians and patients have access to the best e-health tools to support high quality care. I want to echo my colleagues about the importance of virtual care. Using either the telephone or online videoconference to connect with my patients has opened a new world of possibilities in my practice.

The main benefactors are my patients: patients with limited mobility or transportation issues, single parents at home with small children, patients staying at shelters who otherwise would have relied on the emergency department for acute care, employees who can't leave their work sites to get to my office, and patients with substance use disorders who may have a hard time accessing an in-person appointment exactly on time. As well, patients outside of our Central Zone now have more equitable access for medical assistance in dying assessments as most assessors are located in Halifax. Lastly, patients who are vulnerable and at high risk of complications from COVID-19 can access care without coming into a crowded clinic.

Virtual care must be a part of the future for the benefit of patients and providers. That means continuing to include the telephone, since many of my patients are unable to connect for video appointments because they can't access, manage, or understand the technology. Virtual care must also expand and improve to help me connect with my patients in ways that work for both of us. I'd love to be able to notify a group of my patients about a new program at my community health centre or the next flu shot clinic. Secure messaging would allow my patients on daily witnessed methadone to manage changes in their prescription or their pharmacy without having to contact their case manager every time.

It's important for Nova Scotia to invest in secure messaging solutions for providers so there are fast and efficient alternatives for connecting with our patients. Looking forward, I also ask that we plan and implement information systems to ensure that providers and patients can securely access information from anywhere. It's a nightmare trying to piece together different sources of information on one patient. With today's technology, we can and should overcome these barriers. As physicians, we are working to make this happen.

Nova Scotia is a wonderful place to live and work, and I enjoy the privilege of caring for my patients every day. Doctors Nova Scotia is committed to working with our partners and doing our part to recruit and retain physicians in this beautiful province.

THE CHAIR: We will take questions now, starting with the PC caucus. Mr. LeBlanc, for 20 minutes.

COLTON LEBLANC: Thank you to our witnesses for joining us this afternoon. It's a pleasure to welcome you to the committee, and I'd like to thank you and all your colleagues for the very important work that you do each and every day, but particularly over the last number of months, so thank you.

A topic that was highlighted in pretty much everybody's opening remarks was the element of technology and how the changing landscape of primary care has to reflect the technological advances that exist.

Back in February of this year, our Leader, Tim Houston, highlighted that expanding health care delivery through means of virtual care could essentially improve the system, and it was being done in many other jurisdictions around the world. Yet a couple of weeks later, the Premier in this House dismissed the idea, mocked the idea of virtual care, and - to quote him - said that Mr. Houston thought ". . . the best way to deliver primary care was for all of us to sit in our living rooms and call a doctor."

Somewhere between then and March 18th, there was an illuminating realization in the Premier's office that, hey, virtual care can work for Nova Scotians. It's a shame that COVID-19 had to be that mechanism for the government to implement it. I'm delighted to see it being accessed by so many Nova Scotians and to hear of government support for at least until December 31st of this year. We know it's a viable option. Your former president said, "It's simple, it's straightforward and it's good for the public . . . They don't have to leave their homes, they save money, they don't have to find someone to take them in."

I guess the line of questioning to begin with is: How is this going to make delivery of health care more efficient, not only for Nova Scotians but for physicians and members of your organization?

THE CHAIR: Who would like to take that? Dr. MacDonald?

AMANDA MACDONALD: I can start, and then I'll hand to Dr. Hawker. In terms of access and efficiency, what we are seeing now with our virtual encounters is there's subtle time saving, it's the three minutes that it takes a patient to enter and exit the clinic room, not having to drive, and all of that aggregates to increase time for patient care. However, the appointment length themselves are about the same in length. So we're not saving a lot of time there, but I think the access piece comes to the point that I can deliver care anytime, anywhere.

For example, I'm here today as you can see, and not in clinic, so to offset that loss of access, I've opened up several hours of virtual appointments tonight after I put the kids to bed. That's not something I would have been able to do previously because seeing people in person requires front-staff availability, and I would have to get to and from the clinic. There's a lot more flexibility in how we can deliver care in terms of access for that.

In terms of patients, to your point, there's a number of patient populations that really benefit from this access of care. To Dr. Hawker's point, single mothers in particular, those with precarious employment. I have an older practice, and there are so many caregivers that have to take time off work to take their loved one to their appointments. These are some of the demographics I'm finding this most beneficial to.

LEISHA HAWKER: Thank you for the question, and I just want to echo what Dr. MacDonald said. The efficiencies I see might not be as much office space, but it's so much more efficient for my patients in their lives. For people who are working, I've had them in their staff rooms or they've walked a block away on a quick break. They love not having to take a taxi or get in their car, drive to my clinic, wait 15 minutes to see me, and then drive back to work. The amount of time that they miss from work is considerable. I am sure their employers also appreciate this change.

To echo what Dr. MacDonald said about single parents, a lot of my patients have really young children - babies and toddlers - and the last thing they want to do right now is get on a bus and go to a clinic. I love doing my video chats with the moms and parents at home too, because I get to see kind of what their day-to-day life is like. The dog's barking in the background and the children are hopping in and out of the visit and saying hi. It gives me a good picture of what their life is like, especially my patients with substance use disorders. It gives me a better insight into what's going on.

Lastly, the flexibility is key and not just for me, like Dr. MacDonald said with her schedule, but for my patients. Some of my patients with substance use disorders really struggle to attend an in-person visit on time. Before, they would have to rebook for the following week - my addictions clinic is only once a week. Now I'm often able to just pick a time that works for both of us and I can fit them in between my other schedule while I'm at a different clinic and do that visit virtually so that they don't go without the care that they need urgently.

COLTON LEBLANC: Thank you Dr. MacDonald and Dr. Hawker for your answers. We know that as of September 2nd, more than 919,000 services were provided virtually by physicians in Nova Scotia. Do we know roughly how many physicians in Nova Scotia are taking part in the ability to provide services virtually? Just a rough estimate.

NANCY MACCREADY-WILLIAMS: The majority of physicians are reaching to virtual care as a tool in their toolkit. We know that.

COLTON LEBLANC: Is there an idea of how many virtual appointments will essentially transition into a follow-up in-person appointment? Virtual care doesn't replace in-person visits, but rather complements. For the follow-ups, if there's a prescription change or whatnot, or the examples that you noted, is there a rough percentage of how many cases or instances that would be taking place?

ROBYN MACQUARRIE: I can answer from my perspective. As a specialist, we're not often bringing people back regularly. I would say, in my practice about 40 per cent of my visits right now are virtual. There are certain things I have to see with my own eyes. I can't do certain exams. There are some things you can see over a virtual visit. As a gynecologist, it's not appropriate nor possible at this stage to do so.

For me, it's about 40 per cent. It allows me to be a little more efficient in my work day. I was working at about 50 per cent because of COVID-19 regulations - I share an office with other physicians. I'm now able to take that time where I have to space my patients to pop in two virtual visits. It's more convenient for my elderly population. I actually work in Bridgewater and would see women from your area. That's a long drive to Bridgewater from Cape Islands.

In my practice, I've been able to follow up for things that are medication surveillance a little more easily. Really, I'd only bring somebody in if I needed to see them physically. They may ask to come in and if they ask to come in, maybe I'm missing something. Maybe there's something that I'm not getting in that visit, so I wouldn't say that we shouldn't have a follow-up. There might be something that may come up in that virtual visit that we need to follow up with a patient.

COLTON LEBLANC: I guess the benefits to both the physician community and to Nova Scotians may not be endless, but they're certainly not limited. I'm happy to hear that's working very well so far. I hope to hear that it's continued in the future.

[1:30 p.m.]

I guess to home in a little bit more on the topic of today's meeting regarding the ongoing doctor shortage, some may remember back in 2013 that there was a promise that every Nova Scotian would have a doctor within three years of the current government assuming power. Today there are still over 48,000 Nova Scotians who are self-identified on the Need a Family Practice Registry. It's shameful that we have the magnitude of the issue that we have today. That commitment or undertaking at the time by the government, I question if they failed to comprehend the full magnitude of the issue.

Regarding the Need a Family Practice Registry, back in 2017, there was a Statistics Canada report saying that there were 90,000 Nova Scotians on that registry. The numbers were quite similar - 48,000 at the time, I believe. That's like 1 in 20 Nova Scotians that don't have a family doctor, and in my area we're double the provincial average; we have more than 12 per cent. Looking at the 90,000 that was put out by Stats Canada and the

48,000 that we have today in Nova Scotia, how valid do you believe that the data collected by the NSHA for the Need a Family Practice Registry is accurate?

NANCY MACCREADY-WILLIAMS: We can't comment on the accuracy of the Nova Scotia Health Authority's data. We don't have access to that data, so we trust that those are the numbers, that there are 47,000 Nova Scotians seeking access to a family physician. We wouldn't have any other data otherwise.

THE CHAIR: Ms. Adams.

BARBARA ADAMS: I'm going to ask the next few questions. For clarity's sake, Mr. LeBlanc and I are both health professionals and I've used virtual care for 15 years in practice, so I'm delighted that you're finally getting an opportunity to take advantage of that. We believe it should be permanent, we believe the government should announce that it's permanent. There was also - and thank you for sending it to us - the virtual care task force recommendations from February 2020. We would like to see a provincial virtual care task force for the Province of Nova Scotia to make sure that for all the things you're asking for, we are able to take advantage of for you. I just want to be very clear on that.

Regarding the number of Nova Scotians without a family doctor, I have the only constituency in Nova Scotia without a family doctor. There are 86 collaborative health centres, and we don't have one of those either. So I want to go to the Nova Scotia Health Authority's numbers because they are published: *Nova Scotia Health Authority by the Numbers*. The latest ones that just came out show that in 2018-19, there were 2,687 licensed physicians in Nova Scotia, and the new numbers for 2019-20 show 2,287. That's 400 fewer licensed physicians in Nova Scotia according to the NSHA's own numbers. Does that sound accurate to you? Does that match with what you're feeling in terms of your own account of physicians in the province?

NANCY MACCREADY-WILLIAMS: I can speak to our own data. All practising physicians, retired physicians, students, and residents are members of Doctors Nova Scotia. In total - and these are 2020 numbers - we have 2,553 practising physicians, 53 per cent would be specialists, and 47 per cent would be family physicians.

BARBARA ADAMS: What would the number have been last year for the number of physicians? You said it was 2,553 this year? What was it last year?

NANCY MACCREADY-WILLIAMS: From the 2019 numbers, there were 2,498. So there might be a distinction in the numbers by virtue of perhaps the Nova Scotia Health Authority not reporting IWK physicians. That might account for the variation in the numbers. I'm not sure; I can only hypothesize.

BARBARA ADAMS: According to the Find a Family Practice statistics numbers, for the last three quarters there has been an increase in the number of people without a

family doctor in Nova Scotia. Just in the Central Zone in the last quarter, there's an increase of 21 per cent. In the Eastern Zone, it was 5.9 per cent.

According to the *Atlantic Quarterly* as produced for Doctors Nova Scotia - on Page 8 it shows the number of people who say they do not have a family doctor and they have not been looking for one. "I do not have a family doctor and I'm trying to find one." It goes every year for five years straight. If we go back to 2015, it's showing that 4 per cent said "I don't have a doctor and I'm looking", 3 per cent said "I don't have a doctor and I'm not looking". That's a total of 7 per cent of Nova Scotians surveyed who said they did not have a family doctor.

In the second quarter of 2020, 7 per cent said they did not have a family doctor and they were looking and 7 per cent said "I don't have a family doctor and I'm not looking". So that's 14 per cent. That's twice as many people surveyed from five years ago who are saying they don't have a family doctor.

Is it your understanding with the reporting of the numbers for your own profession that more people are reporting that they do not have a family doctor than compared to five years ago based on these numbers?

NANCY MACCREADY-WILLIAMS: Certainly the fact that there's a physician shortage is not a surprise. We've been talking about that for five years. We know on average - based on a physician resourcing plan that all partners would have created and put in place about 10 years ago based on demographics and aging population, including the cohort of physicians in this province - we knew we would need to recruit at least 100 doctors a year for the following 10 years in order to meet the number of physicians who would be either leaving practice, leaving the province, et cetera.

If you just take a look at the last four or five years since physician recruitment has really been a focus of the system - it is a team sport; there's no one organization that can do it on its own. While it is the responsibility of the Nova Scotia Health Authority - or Nova Scotia Health - Doctors Nova Scotia plays a role in partnership. Community recruitment groups like Healthy Pictou County and NOW Lunenburg County, et cetera, are also playing important roles, as is the medical school.

We know that there has been a physician shortage reported - anywhere between 130-odd vacancies right now. That was as high as 200 four or five years ago. Just based on our own numbers of how many members - while we may recruit anywhere from 100 to 150 a year to this province, 80 leave. They either leave practice, retire, leave the province, et cetera so we're largely further ahead every year but we still have a physician shortage. We're not recruiting enough physicians to meet the need right now. That's everybody's responsibility, no one organization's responsibility.

In response to your question: do we get the sense of there being a greater and greater demand for physicians? Yes, we do. We're also seeing the impact on the existing

physicians of those physician shortages in terms of burnout, exhaustion, long hours, and an unsustainable level of stress. That has been markedly so, particularly in the pandemic. I hope that answers your question.

ROBYN MACQUARRIE: One of the things I just wanted to comment on as well is the pandemic expedited a variety of things. If you look at the numbers for physician providers in the province, you'll see that about a third of them are over 55 years of age. That speaks to me about the importance of retraining the people that we have in the province. We've got some really interesting numbers around residents that graduate, who's from the Maritimes, who's not, and how many stay in the Maritimes. Certainly I know of a couple of my colleagues who were maybe shuttled along their pathway to retirement a bit more quickly in the setting of COVID and the risk factors for them working in the public.

In obstetrics, we didn't shut down. We carried on the same as you would in emergency, and the risk of exposure for some of our physicians became an impetus to move toward retirement. Some of those physicians did regular locum work for us, for example, and it was time to move on based on the pandemic.

BARBARA ADAMS: I noted you said, marginally further ahead. The numbers don't suggest that we are in fact further ahead. It does suggest to me, though - according to this, we've lost 400 physicians registered compared to the year before. I know that when we talk about getting people off the Need a Family Practice Registry, we're actually talking about a combination of physicians plus clinical nurse practitioners. There are two different bodies responsible for getting those numbers down, and yet we've gone from seven per cent saying they don't have a primary care provider five years ago to 14 per cent now. That's a "I'm calling you up and asking you" kind of survey.

I'm just wondering, with the time that I have left, if you can talk about what we can do differently moving forward. I know that we had the collective agreement which was a movement in the right direction, we added clinical nurse practitioners and collaborative practices. Yet the numbers are not showing that more people are attached to someone. Virtual care is obviously one strategy to help attach people, but it doesn't replace the in-person visit.

Of all of the things that could be done in addition to what's already in the collective agreement, what would be the one best thing that we could do to help get people attached to a family doctor that's not already happening right now?

ROBYN MACQUARRIE: I think we have an incredible resource in the Maritimes in the form of Dalhousie University. We work closely with our partners at Maritime Resident Doctors to get the information about residents who are finishing, but if you're looking to say, where's that pot of gold we want a piece of? The pot of gold is people who are graduating.

I think we're seeing Dalhousie really do a lot of work right now to transition particularly to community work, so the ivory tower approach of educating medical learners is changing. We're seeing more medical learners come out into the community. The benefit of working in the community is that you may choose to live and practise in the community.

In 2019, 51 per cent of residents that started at Dalhousie were not from the Maritimes. That's huge. Dalhousie is such a draw they were able to bring in 51 per cent that weren't from the Maritimes. Of that, 68 per cent go on to practice. So that means some people go on to finish their residency. They're not lost and say, hey, medicine isn't for me, because frankly they couldn't afford to do that at that stage, but they're probably continuing their education in some manner.

However, 68 per cent are beginning practice. Of that 68 per cent, 74 per cent have been getting practice in the Maritimes. What if we made that share within the Maritimes to be 80 per cent in the Maritimes and 90 per cent in Nova Scotia? What's important in creating that number? They're our resource. In creating that number we need to make the environment appealing to new grads who want to think about some of the things that Dr. MacDonald spoke of - balancing their life and work.

The reality is you're graduating somewhere in your early 30s. Retirement is something you think about closer to 70 as a physician, so you want an attractive place.

AMANDA MACDONALD: Just a further comment to that. As I mentioned, I trained in the Valley residency program in the first iteration of that. As of 2019, out of the 29 residents that completed the program, 26 stayed in Nova Scotia and 18 of which remained in the Valley. Of the remaining, the rest have return of service agreements within Nova Scotia, myself being one.

BARBARA ADAMS: I worked in long-term care for six months at Ocean View Continuing Care Centre during the pandemic, and I know that our particular facility in Eastern Passage lost its medical director and the physicians who were there 15 or 16 months ago. I know that you mentioned that you worked in long-term care.

[1:45 p.m.]

I know that physicians are saying that it's a less attractive place to work sometimes because of the scheduling, the way it works. Certainly one of the things that one of you mentioned about having a better on-call system for physicians - I'm the one who was trying to get hold of you, so I would certainly think that would be a great thing to do.

I'm wondering if you can talk about the fact that physicians are not necessarily wanting to work in that area, and what in the collective agreement addressed that or what else can be addressed, because last year, December I think it was, Debert and Truro long-term care facilities lost their medical director, and they were not going to admit people

back into the facility if they went into hospital. I just wondered if you could talk about the challenges of recruiting physicians for long-term care.

AMANDA MACDONALD: So as I mentioned, I do long-term care work. That's still one of the pieces mentioned in my opening comments, how the assumption is you're available Monday to Friday, 8:00 a.m. to 5:00 p.m. It is not uncommon for me, if I'm home on a Wednesday with my kids, to have to pack them up and go in and sign a death certificate or do orders, et cetera. The way in which the medicine is delivered I think is one of the areas we need to look at reorganizing in terms of the how.

In terms of physician retention, throughout the province, there will be multiple physicians on call formally for long-term care facilities and informally without pay for very low volumes. For me it's not the monetary piece, it's if I can't go to my parents' cottage with no cell service for a week, that's a cost to me. To me that seems like something that could very easily be centralized and rely more on EHS services.

Nurse practitioners are more and more involved with long-term care work, but they're only functioning 8:00 a.m. to 5:00 p.m. They're not sharing the ugly hours, so to speak. I think there's a lot that could be done within long-term care space.

THE CHAIR: Order. Time has elapsed for the PC caucus. We'll turn over to the NDP caucus for 20 minutes. Ms. Leblanc.

SUSAN LEBLANC: Getting back to virtual care for a second, it seems like everyone in this room is in agreement that virtual care is really important and needs to be supported. Of course, we've heard that it's being extended until the end of December, so the big question is: how come only to the end of December? I'm wondering if, without doing the big preamble, can you explain what you understand the hurdles are from the government in keeping the service available? Surely there are conversations going on to extend it past December. Maybe you can't speak about those actual conversations, but what is the government saying is the issue?

NANCY MACCREADY-WILLIAMS: At a high level, I've been told that government is wanting to bring a risk management approach to this topic, and to gain a better understanding of what virtual care might look like post-pandemic. So it's a new modality of communication as between patient and physician, and they're wanting to make sure that there are no unintended impacts of making decisions that need to be made.

We've said very clearly that it needs to absolutely continue - for all the clinical care reasons you've heard my colleagues speak of and patient care reasons, the patient satisfaction reasons - beyond the end of the year. We're delighted that we're going to be starting those conversations with government very shortly about what that could look like moving forward. I'd love to understand what specifically they're worried about. The good news is that every province is having these same conversations right now.

This is an issue that is top of mind for every province. Alberta, for example, has made virtual care permanent, and others are sort of going a little more slowly, so we're delighted to be part of those conversations and hoping that we can address whatever issues need to be addressed prior to the end of December.

SUSAN LEBLANC: One of the things we've heard the deputy minister talk about is quality, safety and control issues – "quality, safety and control" - with regard to the practice and the need to understand best practices.

It sounds to me like maybe you can't help me understand this at this point, but what kind of information exactly is the government looking for? What will they be basing their decisions on? Are they simply privacy issues? Do we know exactly what they're looking for?

NANCY MACCREADY-WILLIAMS: We don't at this point.

SUSAN LEBLANC: Great, thanks. I just want to say the best part about telehealth for me has been the combination of in-person and telehealth. When I had to go to an in-person appointment during the pandemic, there was literally no one in the waiting room and I got in within five minutes. Normally I have, actually, quite a long wait. It was delightful; I was happy.

We were talking just a minute ago about physician burnout. In May 2017, Doctors Nova Scotia partnered with Dr. Michael Leiter from Acadia to conduct a comprehensive study on physician burnout. The report concluded that physicians are struggling to manage workload. Participants scored extremely high on exhaustion, cynicism, and efficacy indicators. Physicians felt a profound lack of respect for their professional expertise and autonomy. Only 40 per cent agreed that it was "It is possible to provide high quality care to all of my patients."

The report concluded that the most impactful way to improve doctor burnout in Nova Scotia was to improve physicians' relationship with the Nova Scotia Health Authority. My first question is: Can you tell us about how the dynamic has evolved since the COVID-19 pandemic - the dynamic of physician burnout in general, but also if the dynamic has changed between doctors and the NSHA?

NANCY MACCREADY-WILLIAMS: Yes. Just speaking quickly to that report and to the science of physician burnout, there is a science to this. There are experts, particularly south of the border - Tait Shanafelt and others - who have studied this. Largely, some of the biggest drivers of burnout are not about a lack of self-care - it's not about doing yoga or more mindfulness training. It's about a feeling of powerlessness and hopelessness with the lived-work experience of being a physician for a whole host of reasons. Part of that, physicians self reported a feeling of being disengaged with Nova Scotia Health Authority at the time.

Your question spoke to what the COVID-19 experience has been. I'm really pleased to say that I think we've been in a crisis and the crisis brought out the best in everybody. Every organization in the health care system rose to the challenge. We witnessed, and were part of, a coming together of the health care system to respond for the common good - for the public good - in a way we hadn't seen in a long time.

I wouldn't want to speak for everybody, but certainly my colleagues around the province feel a level of engagement. Physicians feel a level of engagement with decision makers, particularly the health authorities, that they hadn't experienced prior to the pandemic. It was sort of coming together for the common good and breaking down the barriers and clearing whatever assumptions people might be holding of one another and just getting the work done.

That was our lived experience. We did great work together. I think that physicians are feeling certainly more engaged now than they were at the time of Dr. Leiter's report.

ROBYN MACQUARRIE: I think one of the things that you would certainly think about how people are feeling with respect to burnout at the end of a pandemic - not the end of it, I wish it was the end of the pandemic but after the first wave of a pandemic is, probably not better. That would be what you would think. In fact, I think it goes to show that physician burnout isn't just about long hours. We've all been putting in long hours.

For me, the biggest takeaway and the joy of being a doctor is when my work is valued, and my work is appreciated. I've never had patients more thankful than they've been right now. I've never had patients ask me how I was doing than they are right now. I think de-escalating the tone - there are so many preconceived notions of what it's like to be a doctor, that we're all driving around in our yachts and having the weekend off, and that's certainly not my lived experience.

I think that's one of the things that has really been meaningful, is to have the system. When they asked, we volunteered to show up for whatever was needed, and for the most part it's really just having the system say thank you for being here and having the patients say the same.

AMANDA MACDONALD: I completely agree. I've never felt more valued as a physician as I have these last few months, and it has really kind of given me the juice to do the work. I don't know if Dr. Hawker would agree, but speaking to my family medicine colleagues, I do suspect there are higher levels of burnout because what I have seen in my lived experience has been unprecedented mental health concerns in our daily care.

During the crisis, for every patient, it was three-pronged. There was whatever the visit was for, then you're addressing their mental health concerns, and then they're worried about me and my family. Each encounter had that pattern. It's much better now, but there were times when it was very challenging work because you care so much about your patients and they struggled, they really did, and still are in many cases.

SUSAN LEBLANC: I'm really happy to hear that, and it is kind of amazing how, as you said, Dr. MacQuarrie, that such a terrible time can really shine some light on some amazing things.

In this pandemic, we've heard from some health care practitioners that they're concerned that the COVID-19 testing and 811 times may worsen backlogs within the health care system itself. The concern would be for teachers for example, or anyone who works in front-line care who has a family, whose kids are going to school now.

We've heard that it might especially be true for health care practitioners who have school-age children. I'm not sure how old your kids are, but if your kid needs a test then you're home with the kid and we know the story. Waiting for the testing appointment and the results - and I understand that in some cases health care practitioners have an expedited access to testing, but it still remains a concern in the health care system in general.

I'm wondering if you're hearing this concern from members or if you're experiencing it yourself, and if you can tell us what you know about what's being done to address the issue of the testing and waiting.

ROBYN MACQUARRIE: I can tell you a little bit about the expedited access. The expedited access is available for those of us that are going to be on call. The number of accesses - you can imagine across the country that the need for these tests is quite high, and so there is a limited number of tests available and would be available if you were on call and therefore going to be clinically required, say in the hospital for example.

All of us are mothers too. Mine are school-aged, so day two of back to school we got COVID tested; that was super fun. My husband is a police officer in Cole Harbour and he has been pretty busy too, and so it has been a balance of figuring those sorts of things out.

I think our patients are a little more understanding, but I really feel like that's an opportunity where virtual care came in. The day that my kids didn't go to school and I couldn't go to work, I got my COVID tests organized that day and was then able to see probably about half of my patients. Some of them were scheduled to be virtual and some we were able to call the patient and say, do you think we can address this virtually? In that situation we were able to make a little bit better use of that time.

I am sure, and Nancy has heard me speak of this at length, I've taken many calls in my bedroom with the door locked and in the closet. The first door is to lock so the kids can't get in, and the second door is closed so that you don't hear them screaming at the door. (Laughter)

THE CHAIR: Order. We're going to take a 15-minute break and we'll come back and we'll let you finish, Dr. MacQuarrie.

THE CHAIR: Order. We're going to take a 15-minute break and we'll come back and let you finish, Dr. MacQuarrie.

I forgot to introduce our wonderful clerks, Judy Kavanagh and Sherri Mitchell, and our Legislative Counsel, Mr. Gordon Hebb. Also here is Legislative Television. I knew I forgot something in the introductions. (Laughs) We'll be back. Remember to exit into the anterooms and out. Washrooms are to the left and there's water out front as well.

[2:00 p.m. The committee recessed.]

[2:15 p.m. The committee reconvened.]

THE CHAIR: Order. Dr. MacQuarrie, you may continue on with your reply.

ROBYN MACQUARRIE: I just wanted to continue on the statement that physicians - in particular female physicians - whether we like it or not, typically most of the burden of organizing things like when your children are home from school - that often falls to us. Many families are two-physician families, and the one who can do the virtual care tries to do it, but it's a lot of moving around and the wait times for 811 certainly were an issue, but I do think they've worked really hard to be responsive to the quick turnaround needs.

SUSAN LEBLANC: I also have school-age children and, like many, many people who worked from home, it was a particular challenge to be able to manage all of that, but it's absolutely for sure true that the bulk of the emotional labour of that kind of organizing falls - if it's a husband and wife deal, then it falls to the female, generally.

On that, I'm wondering if anyone would like to talk about child care challenges in general during the pandemic among the membership during the first wave, and what impact they had on the physician work force, and if there are things going on to prepare for a second wave or even, God forbid, a third wave.

THE CHAIR: Dr. MacDonald.

AMANDA MACDONALD: I'm quite fortunate that we have a nanny for child care. It's more costly than I can probably afford at this point in my career, but given the nature of my work and the need for flexibility and the nature of my husband's work, it was the option for us. In my case, she was fantastic and continued and essentially bubbled with us, but for so many of my colleagues, child care was the biggest concern of COVID. Not their personal risk in terms of developing COVID, but how am I going to show up to work - because the emergency departments don't stop, and certainly in some of the physician forms that were online, that is a concern that is often echoed.

There was a lot of discrimination against providing child care for front-line workers. A lot of female physicians had their nannies quit on them because they were

worried about the risk of taking home, given the work they're doing. In terms of active work in that vein, not that I'm aware of, but I know it's been an ongoing concern for many. I think that's far beyond physicians: that's nurses, that's paramedics, that's us all.

SUSAN LEBLANC: I'm going to pass the rest of my time to Ms. Coombes.

THE CHAIR: Ms. Coombes.

KENDRA COOMBES: I want to talk a little bit about succession planning. As in what you've discussed today earlier, Ms. MacCready and Dr. MacQuarrie, you've both stated that 50 per cent of physicians are over 50. I'm just wondering, can you tell us roughly the number of vacancies that would be if it included the pending retirements in the next, say, three years or so?

NANCY MACCREADY-WILLIAMS: The only data that I have around that is what Nova Scotia Health publishes and typically, as I understand it, the process is when a physician is interested and anticipating a retirement and they actually have a date in mind - it could be two years down the road, it could be a year down the road - they're encouraged to let the Health Authority know so that the planning can start right away in terms of trying to find someone to take that spot. Right now I think there are over 130 vacancies. I've seen it as high as 200 three or four years ago.

If I could just add one more thing to this, it's that one process that we talked about in the last contract negotiations that we'd love a little bit more transparency about is a transition-in/transition-out process for practice - the ability for physicians who are anticipating that they're going to retire to, let's say a year out, take on a young physician who might be thinking about taking over that practice. So you'd actually have two physicians working on the same caseload and having the same patient load, but one would be transitioning out and one would be transitioning in. Over the year, the new position to the caseload would be able to be mentored by that retiring physician to get a better sense of their patients' needs. When that retirement date came about, that physician could feel positive about retiring and not leaving their patients in the lurch. That early career physician has had the benefit of that mentorship for the year. That to me is a win-win for both physicians and for the patients.

That process is not clear. We understand it's available, but it's not clear to us who can access that and what the policy is around that. In our world - in terms of recruiting young physicians or new physicians - the idea of having that mentor there in the first months of practice is very, very appealing for new-to-Nova Scotia physicians.

KENDRA COOMBES: We have 181 vacancies. I think transitioning-in/ transitioning-out is a great idea. I know physicians in my area have thought they had doctors in place and found out that they didn't. That kind of one-year mentorship would be - they definitely have it.

You both mentioned as well, as did the other two doctors, that it's great that we have a medical school here in Nova Scotia and that we have doctors there for us. I'm just wondering, though, for Nova Scotians or even Maritime individuals who've gone on to train elsewhere to be physicians, can you tell us what is being done to remove the barriers for those that decide to study out of province?

AMANDA MACDONALD: Currently I am a preceptor, as we speak, for the Nova Scotia Practice Ready Assessment Program. It was developed in conjunction with Dalhousie University and the Nova Scotia Department of Health and Wellness for physicians who trained and did residencies in other countries that aren't typically recognized in Canada as having equivalent medical training . . .

THE CHAIR: Order. Time has elapsed. We'll move over to the Liberal caucus with Ms. DiCostanzo for 20 minutes.

RAFAH DICOSTANZO: Maybe the doctor can finish her comments before I ask my questions. Please go ahead.

AMANDA MACDONALD: That's one program that's being implemented now. It's now in its second iteration. Myself, I am an IMG, so when I did my residency, I matched to the IMG spot at the Annapolis site. That had a return of service with it.

In terms of beyond that, I know Doctors Nova Scotia has worked very diligently - as has the Nova Scotia Health Authority - to create more networking for international medical graduates who are not necessarily from Canada to make that transition. That transition to Canada has been a huge learning curve for many. There has been a lot of work done in that space.

RAFAH DICOSTANZO: Perfect. Thank you. It's an amazing thing to hear from Doctors Nova Scotia here. I'm really looking forward to hearing also about the things that you commented on, how COVID-19 has helped bring the health team or the workers together.

I actually ran into a friend of mine who's a doctor at a funeral last week. I was amazed at how he spoke to me and how hopeful he is. He said we closed all the clinics maybe too soon, but we didn't know what was expected. We know how to do it for the second wave. We are prepared. There was nothing but hope and planning and knowing what they're looking for. I hadn't heard that for a long time. I was really happy to hear how he is talking about the medical system and how he feels he's included in it, which is great. It compares to what you just told us, as well, which is wonderful.

My question is really in regard to the succession. My doctor is in his mid- to late-50s and he took over from his father who was a doctor to my in-laws for many years. Now his son is a doctor. Three or four years ago, his son moved to Toronto. He didn't want to take it.

So I want to know from you, what are you doing to change? You spoke a little bit about the transition or bringing a younger doctor. I want to know why he's running away from his father's practice. I know his father is a very dedicated doctor, he's never able to keep time exactly because he spends time with his patients. He's a very caring, wonderful doctor.

What else are you doing so that we can have those doctors come back? What can I tell my doctor - that things have changed, maybe attract his son back here?

NANCY MACCREADY-WILLIAMS: It's a great question. We've talked about recruitment. With recruitment is retention. There's a couple of things that we talked about in our opening comments that have been very helpful in the recruitment space.

Competitive compensation. We were the lowest paid in Canada prior to these past negotiations for physicians. For many reasons related to compensation, physicians were going to New Brunswick, P.E.I. and Newfoundland and Labrador or elsewhere, to Toronto, other places, to do the same work for significantly more money, and with a supply and demand that made sense to a lot of physicians who graduate with a significant debt load.

We are pretty marketable right now in that space, but it's not just about compensation. Just like compensation is not the driver of engaged employees in a high-performing organization, it's more than just compensation that's necessary. It's a feeling of being valued, being engaged in health system decision making, things like that that are as important to our members. The work environment is as important to physicians as compensation.

The more we can do to improve Nova Scotia as a place to work - and that's everyone's responsibility - will go a long way toward keeping the physicians who come here. We've done some really, really good work around supporting - as my colleague Dr. MacDonald talked about - she's an IMG - that's an international medical graduate, if you didn't know what that stood for - physicians trained outside of Canada.

Right now, close to 40 per cent of physicians who come to Nova Scotia are trained elsewhere. Ensuring that their pathway to licensure, their ability to go from a defined licence with the College of Physicians and Surgeons to passing the appropriate exams and feeling welcomed into their community, we call it a successful pathway to licensure.

That's an initiative that we're working on with Dalhousie University, with Nova Scotia Health Authority, with the College of Physicians and Surgeons, and Doctors Nova Scotia, providing those international graduates with supports from an education perspective, from a mentoring perspective, being settled into their communities, et cetera. That work is under way.

I think another thing that we've seen that will attract physicians back to Nova Scotia is the extent to which - I talked about recruitment being a team effort, and we've seen

communities, particularly rural communities, come together and create full-time positions dedicated to recruiting physicians to their communities. They're doing fantastic work with all of us to make sure that when that physician is being recruited, that they meet the community, that there's a job for their partner, that their kids are introduced to other kids, there's a place to live. It is wrapping your arms around that physician and their family and encouraging them to come here. This is a wonderful place to live and work.

We've seen a real energy to recruiting back to Nova Scotia in a way that we haven't seen for a number of years, and again it's a team effort. I encourage that physician who went to Toronto to come back to the East Coast. It's a great place to live and work.

[2:30 p.m.]

RAFAH DICOSTANZO: He is from here and I'm hoping he will be back.

The other question I had is: What is Doctors Nova Scotia's position on other health care providers like nurse practitioners, physician assistants, and family practice anesthetists? The demand on doctors is so high, so where is Doctors Nova Scotia in relieving some of the things that can be done by others - including pharmacists, as well - which is moving in the right direction so that the doctors work on the more serious and more difficult things. What is your position and how are you dealing with that?

NANCY MACCREADY-WILLIAMS: Doctors Nova Scotia supports collaborative practice. The future is collaborative practice, whether it be at the family physician or at the specialist level; there's enough work to go around. We are a sick, unhealthy and aging population, as much as we might try to deny that. We are top in Canada with a number of chronic diseases. There's a lot of care that needs to be delivered.

Family physicians play a unique role as the backbone of the medical system. Working collaboratively with nurse practitioners, with social workers, with physiotherapists, with family practice nurses, and others in the community is the gold standard. Everybody working to their full scope with a physician uniquely positioned because of their training to deal with the most complex cases, that's ideal, and you need a payment model to support that.

You need a payment model that I'm really pleased we've been able to capture in our recent contract and hopefully finish developing and piloting next year. That's a blended capitation model where a collaborative practice receives income based on the age and gender of their patient base. Then it's up to the collaborative physicians and allied health providers to figure out how to best care for those patients with everybody working to their full scope in a team environment.

That's what we believe is the future in this province. I'll just pass it on to my colleague.

AMANDA MACDONALD: Just to Nancy's point, what she described is where I feel I will thrive. Right now, I'm in a collaborative practice in a fee for service model. We have a social worker, we have a nurse practitioner, we have a family practice nurse and it's great. Our ability to use all of our providers to their maximum potential is somewhat limited by the model we're in but what she described, that's the way I want to practise at my highest level all the time, the highest efficiency and I think that's going to be the best care for patients, as well.

LEISHA HAWKER: I just wanted to add to what Dr. MacDonald said. As you know, I work at the North End Community Health Centre and we are an APP. We practice very differently than most family practices. We are highly collaborative. We have community representatives and physician representatives on our board. We are a charity. We have so many community programs that the standard community health centre might not have.

I also spend a lot of my time collaborating with my mental health workers, my occupational therapists, my social workers - we actually have two now. We actually need maybe even three - one was just not enough at that health centre. Unlike Dr. MacDonald who is fee for service, I am APP and while it's not perfect - the shadow billing definitely does not capture all the work that I do, but it does allow me to spend more time with my allied health professionals to making sure that my patients are seeing the right provider at the right time.

RAFAH DICOSTANZO: I just want to comment that I have worked, actually, with Dr. Hawker for two or three years and have seen the amazing work that the refugee clinic has provided for the refugees when they arrive and how important that is in the first year or two when they arrive. Their needs are so different than the average. They haven't seen a doctor for three or four years. So having them be treated by a clinic that was almost - I thought it was a collaborative, but it had a couple of nurses and they needed a social worker, I believe, but it meant that those did not end up in emergency. And we all know how expensive emergency is.

Having collaborative ideas for different needs of different people is really the way to go. I'm really hoping that with your negotiations you can keep that, because every community has different needs, and it can be supplied, and the doctors become specialists in that community, and things can move much faster and much better for us not ending up in emergency. Dr. Hawker, please.

LEISHA HAWKER: What you said just reminded me so much about the community health centre and the physicians I work with, especially around providing comprehensive care. Comprehensive care in Windsor might look very different from inner north end Halifax. One of our physicians, Dr. Genge, started a managed alcohol program at the peak of the pandemic. I and Dr. Fraser provide care for substance use disorders, and those are unique things that are needed in our community.

For us, that's providing comprehensive care and different models of payment, like the Alternative Payment Plan and the new blended capitation model would allow physicians to rearrange their scope of practice or the health care providers that they work with, depending on what the need of that unique community is. Thank you for reminding me of that.

RAFAH DICOSTANZO: I have one more question about virtual care. How do you see that working with the immigrants, and how have they been adapting to it, and did that work as well?

LEISHA HAWKER: I actually wasn't working at the Newcomer Health Clinic during the pandemic, but I have spoken to some of the colleagues who were. I'm actually working part-time just until a few more weeks, because we have an almost one-year-old at home.

As you can imagine, seeing patients who have limited English proficiency can be challenging even in person. It's surprising how much language comes just from body language and gestures, even when you have an interpreter in the room. I was very lucky to have Rafah as an interpreter many times. Even before the pandemic, sometimes we'd have to phone a patient about some sort of urgent blood test. At that time you would call the interpreter, who would then three-way in the patient, and you can imagine how challenging that was.

Video does help a little bit, because you still get the body cues. However, access to the technology - sometimes the patients might not have a smart phone or a laptop or reliable internet sources, and then also just understanding how to use the technology. You require brochures on how to use Zoom, for instance, in Arabic and other languages. So there are definitely more barriers, and I think the uptake took longer, and I think it's something that they're still working on to improve for the second wave.

RAFAH DICOSTANZO: I'll pass it on to my colleague Mr. Irving.

THE CHAIR: Mr. Irving.

KEITH IRVING: Thank you to our guests and for all of your work keeping Nova Scotians healthy, particularly during the pandemic.

I just want to return to the numbers, which can sometimes be a little misleading. There are different numbers from different places. I think my colleague was referring to - we're short, or we've lost 400 doctors in the last number of years. Your figures show an increase of 55 new doctors. Is it fair to say that that is accurate information? Do you stand by those numbers – they are very solid, based on membership and fees?

NANCY MACCREADY-WILLIAMS: Yes, we have 2,553 physicians who have paid membership dues to us in 2020.

KEITH IRVING: I believe you said that 47 per cent of them were family doctors, which would mean about 26 new family doctors over the last year. I'm just trying to reconcile that with our other fairly solid number, the monthly Need a Family Practice Registry list. From January 2019, we were at 61,000, dropping out around 47,000.

I guess my question is: Of 26 family doctors, what would be their average patient load? I think there is a challenge in trying to determine how many new doctors we need. I think the Health Authority is using 1,300, but it's a bit fuzzy. I've talked to my doctor and he's 1,800 to 2,000. I talked to another doctor at an event who said he can't see how you can do more than 1,000.

Is there guidance that you provide your physicians on how many patients is the right load?

NANCY MACCREADY-WILLIAMS: The short answer is no. It depends on the physician and on their patient base. If they have a relatively young patient cohort, they might be able to carry more than obviously an older patient base.

We hear the figure 1,350 discussed by Nova Scotia Health Authority, but we don't have data on how many is a typical family practice. Perhaps my colleagues might be able to speak to that.

AMANDA MACDONALD: I think when you look at typical, it's important to consider generational. I would venture that your physician who can easily carry 1,800 is probably further along in career. That's the trend that I certainly see. There is a physician who works next door in my building and his patient list is somewhere like 4,000.

I think when we're looking at numbers, numbers don't necessarily mean access. For myself, I've slowly built my practice with the ebbs and flows of having a family. I have it around 1,100 or 1,200. Right now, I'm feeling that that's a bit too much for me with the other pieces of work I'm wanting to do.

When we're doing physician resource planning, I think it's important to look at the incoming physicians who are not going to be carrying the same volume of patients that previous have. Their ability to have access for the patients they do have and their ability to provide comprehensive care for those patients is probably going to be increased.

KEITH IRVING: If it's something you could work on, I think it would help everyone to try and get a sense of how many doctors. I know we're racing to get more and we're making some good progress, but it's always good to know where we're trying to get to a target and identify how many folks are retiring.

The other point to the numbers that I just wanted to confirm with you is that our population is growing. Last year, we brought in 7,580 new Nova Scotians and the year before that was around 5,400. With the same level of doctors, we'd actually have another

12,000 people on that list. We are making progress. Do you think that's fair to say in terms of us both bringing the list down - 14,000 over the last two years - but also with 12,000 new Nova Scotians? Would that be fair to say?

NANCY MACCREADY-WILLIAMS: I can't argue with your numbers. It seems appropriate.

KEITH IRVING: We've had this uptick the last three months because of COVID-19. In your opinion, how has COVID-19 made recruitment more challenging?

THE CHAIR: Order. Time has elapsed. I'm sorry, Mr. Irving. We'll turn to Ms. Adams for three minutes.

BARBARA ADAMS: For clarification, the numbers that I'm using come straight from the Nova Scotia Health Authority and I'll table them if required. It lists the exact number of physicians. They listed it last year. There are 400 fewer physicians listed there compared to the year before so there's no doubt as to what those numbers suggest. The province's own Finding a Primary Care Provider shows a lovely graph that shows exactly how many times in the last year - well before COVID-19.

Frankly, Nova Scotians are tired of there being a reason why we don't have physicians - it's the amalgamation of the health authority. I do not want to hear that it's COVID-19 now as to why. Frankly, Nova Scotia's now the safest place in the world. That should, in fact, help us with recruitment.

The last thing I want to ask with the time that I have is: In the past, we had some amazing emergency room physicians in the Valley who up and left. At the time that they were leaving, they were feeling like their complaints over the last 10 years were not being heard, that they were expecting the recommendations from an evaluation that was done of the Valley Regional Hospital to be implemented. The last note I have was from January 18th saying that 17 of the 25 recommendations had been done.

[2:45 p.m.]

Their primary concern was that they felt that they had not been heard. There was a recommendation that there be considered an ombudsman to help support them when they do have grievances. One of the things that some may or may not be aware of is that in Saskatchewan, there was a recent provincial court ruling that said that criticism of health care systems is in the public interest and when it comes from front-line health care workers, it can lead to positive change.

I'm just wondering if one of you could comment on how well we are dealing with exit interviews on physicians who are leaving, who do have concerns, who feel like their voices aren't being heard. These guys all left which is a terrible loss. Jeannie MacGillivray left. I'm just wondering what role Doctors Nova Scotia has in collecting that information

in exit interviews or ensuring that physicians in this province feel like they're not helpless - I think that was one of the words, the powerlessness?

What avenues have you been trying to work on to improve the sense that their voices are, in fact, going to be listened to in the future.

NANCY MACCREADY-WILLIAMS: Conflict resolution is something that we believe at Doctors Nova Scotia . . .

THE CHAIR: Order. Sorry. Time has elapsed. We'll turn it over to the NDP caucus for three minutes. Ms. Coombes.

KENDRA COOMBES: I have a quick question. This has to do with engaging and recruitment strategies as well as retention. Some people might wonder if the approach to recruitment is piecemeal. We have local community groups. We have municipalities. We have the Department of Communities, Culture and Heritage. I'm just wondering if some people might think it's piecemeal or splintered. Are there pitfalls to having the work not housed in one place?

NANCY MACCREADY-WILLIAMS: I sit on a recruitment and retention advisory committee. It's a multi-stakeholder group. It's chaired by the NSHA and it has everybody at the table. All partners interested in recruitment and retention are sitting around that table including municipalities - everybody.

We've made significant improvements in our coordination efforts. More can be done, but I know the NSHA is preparing a new physician recruitment strategy that we've all had an input in shaping. It has been somewhat scattered, but it's much improved over the past two or three years, I would say. There's still room for improvement, but I think everybody around that table knows that together we can make a difference in physician recruitment.

KENDRA COOMBES: I'll concede my time to Ms. Leblanc.

THE CHAIR: Ms. Leblanc.

SUSAN LEBLANC: I'm wondering about a survey done by Doctors Nova Scotia. The public perception of doctor support by the government during the pandemic was not very high. The average response was 6.3 out of 10.

Can you speak to whether your membership felt supported during the first wave? Earlier on you said that the relationships seemed to be going well, but Nova Scotia Health Authority would not be the only source of support. Do the physicians have access to proper PPE, staffing support, and that kind of thing? Real quick.

NANCY MACCREADY-WILLIAMS: Yes. Community-based physicians now have access to PPE until the end of October. That was an issue at the beginning, but NSHA worked very hard to consolidate procurement processes so we did not see the PPE crisis in Nova Scotia that we saw in other provinces. I was on a call weekly with my colleagues across the country for months on this issue.

I would say on the whole, physicians here have felt more support from government than they have in a long time.

THE CHAIR: Order. Time has elapsed for the NDP. We'll move it over to the Liberal caucus. Mr. Horne. Three minutes.

BILL HORNE: Finish your thought, please. You can finish your thought.

NANCY MACCREADY-WILLIAMS: This government was out of the gate very quickly on two things and showed leadership in Canada in our opinion. One would be virtual care, putting in place virtual care at the same payment rate as face-to-face fees, which was gold standard as far as we're concerned in Canada, and we hope that continues.

As well, an income stability program for physicians who are on fee for service. When essentially the health care system shut down, it enabled those physicians to be redeployed where they needed to be to deliver COVID-related supports. That was best in class as well. We think tremendous leadership on those two fronts for sure.

BILL HORNE: First of all, thank you very being here. It has been really interesting and very thought provoking for all of us, I'm sure.

I'd like to go down the recruitment street, to talk about recruitment for rural areas. In particular, how you might change your recruiting ways to encourage new doctors to go outside of the metro area.

ROBYN MACQUARRIE: I'm a pretty passionate advocate for recruiting to the community. I actually am the opposite of a lot of people in that I live in the HRM and drive to my community. I love working in the community so much that that works for us - my child care is here, I can be at work and not worry.

One of the things that we're really seeing is the leadership of Dalhousie. Dr. MacDonald talked about her experience. We are now seeing as a maternity provider, we have a great interest in encouraging people to do collaborative practices that have many different facets, one of which being providing maternity care. We're now getting more and more demands to come to Bridgewater to work on our model where we have an integrated model of midwives, family physicians, and obstetricians.

The important part there is that the midwives feel supported, the family doctors feel supported, we as the specialists feel supported in that the use of our time is efficient and

we talk about working at your best - everybody feels good if you're doing what you need to do and what you're uniquely positioned to do. They get to see this model. The way people previously were trained, it all happened in the ivory tower, and we know that's why everybody moves to Toronto. If you want to engage people in your community, you need to bring them to the community and let them see the benefits of working in the community.

THE CHAIR: Order. Time has elapsed. We will ask for closing remarks briefly. Dr. MacQuarrie.

ROBYN MACQUARRIE: I want to thank you all for inviting us here today. One of the things that I think is really important about us being here today is exactly what we've talked about today, physicians need to have a role in the system in which we're expected to work. We thank you for the invitation to share our experience.

When we were invited here, it was a totally different world, and we are now still having to deal with concepts of physician recruitment and retention. For example, I previously had a job in the Nova Scotia Health Authority before I became president of Doctors Nova Scotia, and we were able to recruit somebody from South Africa. Well he's still coming - COVID has delayed that move by a year because he wasn't allowed to leave South Africa.

We've seen so much good happen in Nova Scotia. Somebody previously said it's the safest place to be right now, and I think we all feel pretty happy to be here, running around with our masks to keep each other and our families safe. But the recruitment and retention work also has to be flexible. It's important that we don't just say, well actually, we did a study in 2014 and it's important to the graduating residents then that we did X, Y, and Z. Virtual care is where we're at right now. We all need to figure out a way because we know when we said two weeks back in March that it was never going to be two weeks and it's important that we have a plan.

This is going to be our lives for the next year and something. We need to keep our elderly patients safe, we need to keep our immuno-compromised patients safe, we need to keep the economy going by keeping people working. I'm glad that you have an interest in hearing what we think because we're actually contributing to the system, but it also makes us feel part of the system to be invited to share our knowledge.

THE CHAIR: Thank you for being here with us today. We have a business meeting so you may be excused. Often the media is waiting outside - I think the Red Room is where they're taking questions. Somebody will direct you if they want to speak to you.

We are doing an agenda setting today. Before we start, I just want to clarify a few things with the proposed witnesses especially - just what we are doing. To avoid procedural confusion, we're going to ask to discuss each caucus's proposals before the formal motions are made. Also, after discussion, ask each caucus to state each topic clearly in the form of

a motion for the record. This is to help out our clerk. They can make a separate motion for each topic or you can do one motion with all the topics.

We are also asking that members indicate where they would accept a substitute, we had instances where the deputy minister wasn't able to come, but we had a designate in, so we want clarification. That way it saves the clerk a lot of back and forth and a lot of confusion.

Also, in the case of a staff change - and you'll see one here on an ask when we go through - it would be helpful to state for the record whether the committee wants an individual to appear or the person holding the job title.

You'll also notice there's a seventh topic that came in. That was one that was sent over from the Veterans Affairs Committee. We won't take it as any of our topics. If we choose to do it - and that will be a vote - it will be added on after everyone has their topics as an extra meeting - not an extra meeting, but it would be the next meeting before we go through an agenda setting again. Ms. Adams.

BARBARA ADAMS: We were looking for clarification on that. I was on the Veterans Affairs Committee when that motion was made. It was an NDP motion, so therefore it was suggested that the NDP consider that for a topic for this committee.

What I'm concerned or confused about and looking for clarification on is, the NDP have two topics. Had they wanted that to be one of their two topics, would that not have been the opportunity to put it in at that time? We all have a set number of topics we're allowed to introduce - can another committee simply add topics to our agenda without it being one of our own personal picks?

THE CHAIR: I'll ask the clerk for clarification.

JUDY KAVANAGH (Legislative Committee Clerk): They put forward two suggestions, but at the end of this exercise, I think the NDP will have one topic that the committee has chosen. This other one at the bottom that came to us from the Veterans Affairs Committee - yes, it was raised in the Veterans Affairs Committee by the NDP members, but it was referred to this committee by the entire Veterans Affairs Committee in a letter from the Chair, Rafah DiCostanzo.

It's my understanding that past practice has usually been that it comes from a committee - it doesn't come from a caucus - but that's up to members to decide.

BARBARA ADAMS: It's my understanding - because I was at the meeting - that the intent was that a committee had an idea, therefore it would be considered not as an additional item on the agenda, but that the Party that wanted to bring it forward could consider bringing it forward here.

I guess I'm questioning, does that mean that if we're at another committee like Community Services, the Liberal Party or the PCs or the NDP could put forth two ideas and have it voted up here, and that would extend us to being allowed to submit possibly five agenda items. I'm just wanting clarification that if that's the case, that's a precedent that may be new.

[3:00 p.m.]

THE CHAIR: Mr. Irving.

KEITH IRVING: I agree with my colleague here to the right. My understanding and our past practices have been is if there are external requests, whether that be public or in this case it's a committee, that any one of three caucuses could choose to put it forward as one of their two, three, or one subjects. That's the process that we've used.

I think the argument that Ms. Adams makes is that we could end up with five or six requests that get tacked on to the six slots that we have now. I would suggest that that other can be put forward by any one of three caucuses as one of their allotted topics.

THE CHAIR: Any comments? Mr. Hebb?

GORDON HEBB: It's entirely up to the committee.

THE CHAIR: Okay, Ms. Adams will make a motion.

BARBARA ADAMS: I would like to make a motion now that when committee topics come through other committees, that they not be tacked on to the allotted spots for us to propose a topic, but that any one of the Parties have the right to introduce that topic as one of their slotted proposed topics.

THE CHAIR: Any discussion? Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

We will delete that one unless the NDP would like to add it to your list of topics when we come to it.

We'll start with the Liberal caucus. You get to bring forth three topics of preference. Mr. Irving.

KEITH IRVING: Do you want all three?

THE CHAIR: You can do all three or one at a time.

KEITH IRVING: We'd like to propose the following three topics: the Ronald McDonald House and its role in the community, witnesses would be staff at Ronald McDonald House. The second topic is with respect to ongoing work with organ donations, and the witness would be Dr. Stephen Beed and any members of his team that he would like with him. The third topic is local efforts to welcome doctors to community, and we would like the witnesses to be Kerry Munro and Rebecca Rose of the Yarmouth Chamber of Commerce.

THE CHAIR: So there's three topics. That is the motion, so we'll call for the vote. (Interruption) Oh, did you want discussion? Okay. Ms. Leblanc.

SUSAN LEBLANC: I don't remember how this process works, I'm fairly newish to this committee. I just wanted to talk about the Liberal caucus' proposals. I think all of them are really important subjects, but I do recognize that our committee has been on hiatus as it were - a forced hiatus for the last several months - and we're in the middle of a global health pandemic. I feel like what I would like to see on the agenda items in the upcoming meetings are conversations that have to do with our health care system and how the pandemic is affecting it, and how we are reacting to a global health pandemic.

Obviously, and I want to reiterate this: these are important topics, but I feel like there are more pressing topics at the moment. I frankly am baffled by some of the choices here when there are seemingly many, many things to discuss.

THE CHAIR: Ms. Adams.

BARBARA ADAMS: I guess I would like to echo those same sentiments as well, and the one item that is being left off is the one dealing with staffing levels for our health care system. I agree with the NDP member that COVID-19, long-term care - all these issues should have been on their list.

Moving forward we could also re-entertain the thought of moving to having more Health Committee sessions to make up for the fact that we were shut down for seven months. We won't introduce that again today, but I think that, moving forward, we definitely want to focus on some of the key issues that we're facing because of the pandemic.

THE CHAIR: We have a motion on the floor. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

The Liberals have their three topics. Noted by the clerk. Thank you.

The PC caucus. Ms. Adams.

BARBARA ADAMS: The very first topic as listed is the issue of long-term care. That was the sector that was most impacted by COVID-19 and the wait times. That is number one . . .

THE CHAIR: Can I interject? We only have seating for six people. You have more than six witnesses on your list. Can you be specific as to who your preferences, I guess, are?

BARBARA ADAMS: I don't want to leave out any one of the unions and we've had the deputy minister here before, so I'm going to suggest we leave out the deputy minister. We do need Ms. Lopez and Ms. Stevens.

THE CHAIR: Okay. Noted by the clerk. Your second topic?

BARBARA ADAMS: The second one that we want to bring in is related to the health care system human resources because of the shortages that we're continuing to experience in most of the sectors in health care in the province.

THE CHAIR: Okay. I just wanted to interject that I was in discussion with the clerk prior to this - and this is just a reminder for all members. It's my understanding that you may invite a minister, but they are not compelled to attend, nor any MLA. You can invite. In the future dates when people are listing their witnesses, be aware of that. We checked that out with Mr. Hebb and that was his wording.

Mr. Irving.

KEITH IRVING: Just with respect to the first topic, it's fairly general in its name here - long-term care. Are there any specifics in the long-term care system that you are interested in discussing here? I noticed that the NDP have a similar topic with respect to long-term care and COVID-19 and preparation for a second wave. I don't know if that's the one that they're bringing forward, but I'm just wondering if the PC caucus could enlighten us on exactly what aspects of long-term care they'd like to have witnesses present on.

BARBARA ADAMS: Certainly. Given who the people are that we have listed there, there are huge staffing issues in long-term care. There are also major challenges with infrastructure spending as well as budget and how human resources have been allocated both before, during, and now after COVID-19.

This is specifically looking at how long-term care is staffed, the shortages that are being faced by these facilities, the lack of physicians and the impact that that has had on them. When they looked at Northwood, an inquiry wasn't done - it was just some recommendations without an actual report. We want to delve more into what happened in terms of long-term care across the province because we are going to be possibly facing a second wave. We want more information with respect to being prepared for the future.

THE CHAIR: Is there any further discussion? Would all those in favour of the motion, please say Aye. Contrary minded, Nay.

The motion is carried. We have the two topics for the PC caucus.

Turning to the NDP caucus - Ms. Leblanc.

SUSAN LEBLANC: Given the result of that vote, then we would like to put forward our second topic which is the emergency mental health care/services.

To be more specific about representatives, I would suggest that we would like to hear from the Deputy Minister of Health and Wellness, the head of Mental Health and Addictions from the NSHA, the head of mental health at IWK, and a representative from the North End Community Health Centre - somebody who was a lead on their mental health walk-in clinic pilot. I don't know who any of those names are.

Given what we just heard from our guests, especially in relation to COVID-19, we know that mental health and addictions is a huge issue and emergency mental health is a huge issue in our province. Given what we've just heard from doctors, recognizing that their patients' mental health has deteriorated over the last several months because of the COVID-19 pandemic, we feel that this is an even more important topic to bring forward at this time.

THE CHAIR: Would you like to make that as a motion?

SUSAN LEBLANC: Yes, that's a motion.

THE CHAIR: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Under our correspondence, we have a letter from Dr. Kevin Orrell, Deputy Minister of Health and Wellness in response to a request for information made at the September 8th meeting. Members were emailed this document on October 5th and again this morning.

Mr. LeBlanc.

COLTON LEBLANC: I would like to take the opportunity to make a motion. We discussed at great lengths with our witnesses this afternoon the benefits not only for the physician community, but for Nova Scotians from Yarmouth to Sydney. There are discussions that are hopefully going to be taking place sooner than later to extend telemedicine and virtual care in our province. However, what I fear is that we might be going on a three-month to four-month re-evaluation of that.

Our witnesses also spoke about the ability of virtual care to provide some flexibility to improve their work conditions, albeit some minor element. Dr. MacQuarrie said that virtual care should be here to stay. They have made their position very clear here this afternoon.

I'd like to make a motion that we write to the new Minister of Health and Wellness to extend virtual care services while at the same time forming a virtual care task force as has been done at a national level. This would be to ensure that all stakeholders that need to be at the table can be consulted to ensure that virtual care is appropriately rolled out effectively to not only benefit all of our population, but also have the positive impact on our doctors as well.

THE CHAIR: There is a motion on the floor. Mr. Irving.

KEITH IRVING: I won't be supporting this motion of creating a task force when Doctors Nova Scotia is in the middle of having these discussions with the department. It does not seem appropriate to me. I think we all heard Doctors Nova Scotia position on virtual care and I think we're all in agreement that it is of value. I'm not disputing that, but for this committee to get involved in the negotiations between the department and Doctors Nova Scotia would be inappropriate.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: I believe our department's already working on this and with the extension they'd be working to figure out what is positive and how things can be implemented correctly. They are working and looking into it.

THE CHAIR: Mr. LeBlanc.

COLTON LEBLANC: What I'm not implying by this motion is to interfere with negotiations between Doctors Nova Scotia and the department. There is quite possibly an impact that the department might not want to commit to this for a prolonged period of time. Doctors Nova Scotia have clearly outlined their position on virtual care, and 95 per cent of Nova Scotians have either had complete satisfaction or part satisfaction with virtual care to date.

I want to ensure that whether it be DHW, NSHA, Doctors Nova Scotia, or other stakeholders, that there can be adequate and proper consultations with all stakeholders involved. If we're talking about billing codes, for example, or any other barriers to implement this for a long term, this is something that we as a Party stand strong on and I'm calling on all members . . .

THE CHAIR: Order. The time has elapsed. The meeting is over.

[The committee adjourned at 3:15 p.m.]