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STANDING COMMITTEE

ON

HEALTH

Thursday, July 15, 2021

Video Conference

Recruiting and Training Medical Students in Rural Areas

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STANDING COMMITTEE ON HEALTH

Rafah DiCostanzo (Chair)
Hon. Leo Glavine (Vice-Chair)
Hon. Tony Ince
Hon. Ben Jessome
Bill Horne
Barbara Adams
Colton LeBlanc
Susan Leblanc
Kendra Coombes

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Dalhousie University, Faculty of Medicine

Dr. Katherine Stringer, Head, Family Medicine Department
Dr. David Anderson, Dean
Dr. Roop Conyers, Site Director, Annapolis Valley Residency Training Site

Nova Scotia Health Authority

Dr. Nicole Boutilier, Vice-President, Medicine
Dr. Aaron Smith, Executive Medical Director, Northern Zone
Katrina Philopoulos, Director of Physician Recruitment

House of Assembly
Nova Scotia

HALIFAX, THURSDAY, JULY 15, 2021

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Rafah DiCostanzo

VICE-CHAIR
Hon. Leo Glavine

THE CHAIR: I call this meeting to order. This is the Standing Committee on Health. I'm Rafah DiCostanzo, the MLA for Clayton Park West, and I'm the Chair of this committee.

Today we will hear from the Dalhousie University Faculty of Medicine and the Nova Scotia Health Authority on the topic of recruiting and training medical students in rural areas.

For members and witnesses and the committee clerk and the Legislative Counsel, keep your video on throughout the meeting and the microphone on mute unless I call your name. All other staff should have their audio and video turned off. If you have another device, this is the time to make sure it's on vibrate or off, if you don't mind, and try not to leave your seat unless it is absolutely necessary.

I will now ask the committee members to introduce themselves, starting with Honourable Leo Glavine.

[The committee members introduced themselves.]

THE CHAIR: Now I would like to welcome the witnesses and I would like to ask them to introduce themselves and their opening remarks. I did say that if you don't mind just waiting for me to acknowledge you before you speak. That gets hard sometimes during the meeting, but please make sure I say your name before you speak, and we'll try to get the members to identify who they want to answer the question if possible. If not, it goes to the first person on my list - am I correct, Ms. Kavanagh? Will it go to the dean normally for the Faculty of Medicine, or Ms. Stringer? Probably the dean because he's doing the introductory remarks so I go to you, unless you feel somebody else would answer that question more appropriately or more knowledgeable about that.

For the Nova Scotia Health Authority, I believe it was Nicole Boutilier who is going to give the remarks - I will send it to her first. We can start with the introduction and opening remarks.

DR. DAVID ANDERSON: Thank you for giving us the opportunity to appear before the committee today. My name is David Anderson, I'm the Dean of the Faculty of Medicine at Dalhousie University. Before I begin, I do want to acknowledge that Dalhousie Medical School sits on the ancestral unceded and unsurrendered territory of the Mi'kmaw nation. We are all treaty people.

I'm pleased to be joined by Dr. Katherine Stringer, who is the Head of the Department of Family Medicine at Dalhousie; and Dr. Roop Conyers, who is our Director of our Annapolis Valley Family Residency Training Site. I'm also pleased to be here today with my colleagues from Nova Scotia Health Authority. Our Dalhousie clinical faculty in Nova Scotia all have appointments with either Nova Scotia Health Authority or the IWK, and much of our distributed training occurs in Nova Scotia Health Authority facilities. We rely on the excellent collaboration and support of these organizations to train our future physicians.

I want to take this opportunity to acknowledge the support of the Department of Labour and Advanced Education and the Department of Health and Wellness. I also look forward to briefly sharing with the committee the actions of Dalhousie Medical School that we've undertaken with our partners to train medical students and residents to meet the needs of rural Nova Scotia.

Dalhousie Medical School has a long-standing tradition of producing excellent physicians. Our medical school trains 124 medical students per year and, in addition, over 500 medical graduates in over 50 specialty and sub-specialty residency training programs, including family medicine. Over 67 per cent of all physicians practising in Nova Scotia have trained at Dalhousie at one time. It's clear that an important strategy for the sustainability of our provincial health care system to have physicians live and work in Nova Scotia is to have a large and successful medical school at Dalhousie.

We're committed to training physicians that address the needs of our province. Access to family physicians for Nova Scotians, particularly in rural settings, is an issue the

medical school is acutely aware of. This resulted in two strategic shifts in medical education at Dalhousie over the past several years.

First, we're providing a much greater emphasis in our undergraduate program on training in family medicine. To reach our goal of having 50 per cent of our graduates pursue a career in family medicine, we are working to ensure these students have an excellent understanding of the specialty of family medicine and see it as a fulfilling and challenging career choice.

To that end, we have significantly increased family physician involvement in the teaching of our students and increased the overall involvement of family physicians in leadership positions at Dalhousie. For our students, we've increased the number of family medicine training experiences and have introduced these in the first year of medical school.

Second, we recognize the need for physicians outside of the urban Halifax area. As a result, we're providing our students and residents more educational opportunities throughout the province of Nova Scotia. In 2019, Dalhousie introduced the Longitudinal Integrated Clerkship Dalhousie program in Nova Scotia, where four third-year medical students spent their entire year of medical school training under the direction of physicians in Cape Breton. This program has been further expanded to the South Shore in September 2020, where the communities of Bridgewater, Lunenburg, and Liverpool welcomed five medical students from Dalhousie University.

This program would not have been possible without the tremendous amount of community support we have received. This includes community preceptors who have agreed to take on these learners in their practices and the patients who are active participants in our students' learning.

Dalhousie is also committed to providing residency training experiences throughout Nova Scotia. Our family medicine training program under Dr. Stringer's direction is a leader in this regard, as over 50 per cent of our 84 family medicine residents train in one of our four distributed centres in southwest Nova Scotia, the Annapolis Valley, North Nova and in Cape Breton.

Although most of our Royal College specialty training programs are based in Halifax, we're committed to ensuring that residents in these programs also have training experiences throughout our province. Our data have demonstrated that family medicine residents who train in smaller communities in the province are highly likely to stay in Nova Scotia and practise in the same or similar communities.

For example, in Dr. Conyers' site, of the 39 residents who completed their family medicine training since 2012, 34 of these have chosen to stay and practise in Nova Scotia, and over 90 per cent of these who have stayed are working outside of Halifax.

Medical school admissions pathways programs are a means for us to ensure our physician graduates reflect the communities we serve and represent the rich diversity of our region. These programs have resulted in the admissions of increased numbers of Black Nova Scotian and Indigenous students over the past five years. With a focus on diversity, equity and community representation, we're providing a better educational experience for our students, leading to improved health care of the people of our region.

We work closely with Doctors Nova Scotia and the provincial college in efforts to support the training of physicians in our province and the development and implementation of innovative programs such as the Nova Scotia Practice Ready Assessment Program.

Thank you again for the opportunity to be here with you today, and we look forward to answering your questions.

THE CHAIR: Thank you very much, Dr. Anderson. That was wonderful. Next we have Dr. Nicole Boutilier's opening remarks as well.

DR. NICOLE BOUTILIER: Thank you, Madam Chair, and thank you, Dr. Anderson, and thank you to the committee for the opportunity to appear here today. My name is Nicole Boutilier and I am a Vice-President of Medicine for the Nova Scotia Health Authority.

I'm joined today by our Director of Physician Recruitment, Katrina Philopoulos and Dr. Aaron Smith, our Northern Zone Executive Medical Director. Dr. Smith is involved in the North Nova family medicine residency training site and has a lot of experience through his clinical career mentoring medical students and residents. We are happy to be here to highlight the importance of training future doctors.

Our model of distributed medical learning is seeing real impact across rural Nova Scotia. Physician recruitment and retention is a high priority for the Nova Scotia Health Authority. Over the last few years, we have worked diligently to create strategies and a team to improve our position in the highly competitive global recruitment marketplace. We have been successful in bringing more than 600 doctors to the province by focusing on a variety of strategies.

One of our most important strategies is our increased focus on medical learners. As Dr. Anderson said, Dalhousie Medicine School graduates make up more than 60 per cent of our current physician work force in Nova Scotia. We know focusing on our distributed medical education program is critical to recruitment success, as residents are much more likely to stay in practice in the community where they have trained.

This is for several reasons. The age and life stage of residents has many of them planting roots for the future. They value the connections and mentorship of the preceptors whom they work closely with and they build connections to the community they are serving

during their years of training. This presents an incredible opportunity for us as we work to highlight practice opportunities in communities across Nova Scotia.

[1:15 p.m.]

We work closely with Dalhousie on medical resident training. Preceptors and program leads are cross-appointed with Dalhousie University and the Nova Scotia Health Authority. In our Medical Affairs department, we support learners with our recruitment team and our medical education team. Our medical education team provides administrative support for medical learners, ensuring they are supported in accordance with the Maritime Resident Doctors Collective Agreement. This past year, we collaborated with Dalhousie to redesign the medical education support in each of Nova Scotia Health Authority's regional facilities.

Additional administrative support was added to support post-graduate and undergraduate medical learners and to help coordinate their presence at the regional sites. This additional support speaks to the importance of the coordination of residents at our facilities and is support required for residents and preceptors within Nova Scotia Health Authority.

We also work closely with Dalhousie and the College of Physicians and Surgeons to support the Practice Ready Assessment Program. This is a program that offers a pathway to licensure for family doctors who have trained outside of Canada. This program requires clinical field assessments and offers candidates a return-to-service contract, which matches them to communities in need. Dalhousie's Department of Family Medicine hosts the program and works closely with us and the Department of Health and Wellness on their assessments and match locations.

In 2019, through the work of our provincial recruitment and retention committee, we added a physician recruitment consultant focused on medical residents. Despite the pandemic, we have seen improvement in the early and consistent connection between all medical learners and the Nova Scotia Health Authority. Through COVID, our recruiters plan resident-specific events through virtual or social distance means, leveraging community partners and Doctors Nova Scotia resources to make an impact.

Our resident recruiter also works to connect with residents at medical schools across Canada and abroad to connect them and recruit them to Nova Scotia, particularly when they have come from this area. Last year, our recruitment team collaborated with residents, program leads, and coordinators to create a resident engagement strategy to continue to coordinate and connect with the family medicine residency program teams of residents. Our goal is to increase the retention of Dalhousie medical residents to the province even further.

The other impact of distributed medical learning is the value it brings to preceptors. There are many rewards for practising physicians to stay involved with students and

residents. We consistently hear from physicians working in rural Nova Scotia that this experience enriches their medical practice and improves their satisfaction. These opportunities are valuable for communities, residents, and the physicians we are trying hard to retain across our province. In the latest master agreement between the Department of Health and Wellness and Doctors Nova Scotia, there was financial support added for preceptors to recognize the critical role communities play in the education of students and residents.

Our work with medical learners, communities, and other recruitment partners across the province has revealed opportunities to support needed infrastructure for residents. We received investment from the government for the Valley Regional Hospital site to construct a facility that will be used for the family medicine residency program. On the South Shore, we received funding to renovate facilities to support the Longitudinal Integrated Clerkship Dalhousie program, to name a few infrastructure supports received.

In other towns and communities, local organizations are coming together to offer apartments or housing for residents who are staying in their communities. All these things are helping bring residents to rural Nova Scotia, and we are seeing the difference.

We believe that adding residency sites and rural programs, increasing the number of Nova Scotians attending medical school, and getting medical students access to learning and mentorship at sites across the province will increase our retention of this valuable resource. We are grateful for the support we have received as one of the only provinces in Canada making these investments upstream to improve recruitment now and into the future. We continue to work to enhance these strategies and seek opportunities to grow these programs.

We have something unique happening in our province. There is an immense energy to support resident needs and recruitment in our communities, whether it is Doctors Nova Scotia sponsoring virtual cooking classes for residents and preceptors, or a local community recruitment committee supporting a rural week event. Through the many partnerships with Dalhousie, community recruitment organizations, Doctors Nova Scotia, MarDocs, and the Department of Health and Wellness, Nova Scotia is creating the conditions for more residents and family doctor recruitment and retention. Thank you for this opportunity and we look forward to answering your questions.

THE CHAIR: Thank you, Dr. Boutilier. Thank you very much to both of you. I just want to explain that the questions start with the 20 minute period for each of the caucuses, starting with the PC caucus, followed by the NDP, then the Liberals, and whatever time is left, I'll divide it into the second round.

We will add three minutes, Ms. Adams. We actually were two minutes and forty-five seconds late starting, so we will add three minutes after 3:00 p.m. to make sure we have that covered.

We can start right now with the PC Party. M. Leblanc, go ahead please.

COLTON LEBLANC: Thank you very much to our witnesses for joining us. It's certainly an important topic, one which we discussed back in March with representation from the Yarmouth and Area Chamber of Commerce, who do exceptional work - part of the community that I represent here in southwest Nova Scotia.

I think obviously it doesn't matter which side of the aisle you're on in the Legislature, we want to be successful when it comes to doctor recruitment and retention. A point that had been made by Rebecca Cassidy Rose, community navigator in Yarmouth, is that happy doctors recruit happy doctors, and that really sent a resounding message when it comes to not only recruiting new physicians in our communities, but also retaining the ones whom we have here.

I need not remind committee members especially that here we are with 69,000 Nova Scotians without a primary care physician - a provider, rather. That number has increased 50 per cent over the last year. I have a question, though, when it comes to these numbers for representation from the Nova Scotia Health Authority. It has been communicated that over 179,000 Nova Scotians have found a family practice since the inception of the registry. There's an awful revolving door process here that people find themselves, find a practitioner, lose a practitioner, find a new one.

I'm just wondering, has the Health Authority kept track of that data over the years, of how many Nova Scotians may be duplicates in that 179,000?

NICOLE BOUTILIER: I don't have that information in front of me today. We can certainly get that for you or see if that has been captured. We do know that physicians today are much more mobile and change their practices around early, and particularly early in their career. So there are other opportunities for family doctors. Family doctors are the backbone of our system and they are providing many ways of caring for patients, not just in offices but in our hospitals, in emergency rooms, in all kinds of settings, including specialty things like geriatrics or oncology.

There have been a lot of people placed, but I don't have that information that you're looking for.

COLTON LEBLANC: I'd appreciate if the committee could be forwarded that information if it does exist.

When we look at the number of unattached patients across our province, the community that I represent sits at around 13.8 per cent of our population that has self identified needing a family practitioner. Despite recruitment efforts, we remain among the highest in the province. We are obviously facing a number of challenges and barriers to overcome, and some of those have been expressed in your opening remarks.

If there was one key thing that could be the golden solution, what would that be for the Nova Scotia Health Authority, to significantly improve our recruitment efforts for physicians in our province?

NICOLE BOUTILIER: Thank you for the question. I think I will point back to the training piece, first of all, because certainly these investments that we're making in training and medical students are a long-term strategy that will continue to pay off in the future and is one of our main focuses. I'll let Dr. Anderson talk a little bit more about that, how the training is changing in that.

Just before that, I will mention one of the opportunities that we have right now is around virtual care, and we currently have a virtual care pilot going on in the Western Zone and the Northern Zone, and it will give the opportunity for almost 30,000 people that are on the list to have access to care that would initially be provided by Nova Scotia physicians virtually. However, should they be identified as needing to be seen as well, there is a way that we link them to a clinic which will see them as well in person.

We're very excited about the possibilities of providing primary care access to multiple people who are waiting on the list, and with the evaluation of that and potential expansion across the province, that's a really exciting opportunity that we have to learn from some of the things that we learned from COVID around the benefits of virtual care and expanding them out through the communities in different ways. I'll maybe throw it over to Dr. Anderson.

DAVID ANDERSON: If I could add, I think our strategy and our collaboration with Nova Scotia Health Authority around training residents in communities around the province is a model of success and one that we want to build upon.

Our training program in the Yarmouth region is an example of success there with really strong relationships with the community in Yarmouth, as you've alluded, and again, with the residents that are graduating from that program choosing to stay in the Yarmouth area to practice, which is what we're so gratified to see when that happens.

The training experiences that these residents receive are phenomenal in the regions around the province, and they are so enthusiastic about how they are embraced by the community that as they go about their daily lives and are in grocery checkout lines and in banks, they're often asked, when can you sign me up as a patient after you complete your training?

It is just an incredibly positive experience for the leaners, for the community, along with excellent education for our residents. We have some people who can speak very well about what those experiences are like from Dr. Stringer, who is our Head of Family Medicine. If time allows, I would love for her to comment on this as well.

COLTON LEBLANC: I'd like to get on to a couple more questions though, but thank you for that response. I do want to note that I'm very happy to see that government has embraced virtual care. It's something that our Party came out strongly in favour of in February prior to the pandemic. It's working in many other jurisdictions, but it had to take a pandemic to get the ball rolling here in Nova Scotia. Nonetheless, it is working and being welcomed with open arms.

My last question before I pass it on to my colleague, Ms. Adams, is in two parts. The first part is, Ms. Rose in the committee meeting on March 9, 2021, said that in a dream world having an Atlantic physician licensing system would make her job a lot easier. I'm interested to hear feedback to that part of my question.

I guess it ties into locums, because locums can come from out of province obviously if they are licensed. Seeing the Maritime Resident Doctors data from 2020, there are a lot of physicians who are - 48 per cent of them in the job breakdowns are coming out and doing locums. I'm wondering why that is, seeing the need for permanent family physicians, why they'd be going down that route versus establishing themselves with a permanent practice.

[1:30 p.m.]

DAVID ANDERSON: I wonder if maybe I could ask Dr. Stringer as the Head of Family Medicine to address that question.

THE CHAIR: Dr. Stringer.

DR. KATHERINE STRINGER: You are correct, M. LeBlanc, that a lot of our graduates are choosing to do locums after finishing practice. In some regard, this can be seen as a positive thing, because they are investigating different types of practice. We are very supportive of family physicians embracing broad-scope, comprehensive practice, so embracing opportunities that expose them to practice both in the office as well as emergency units, the long-term care facilities, obstetrical wards, et cetera.

This is indeed a way that they are using to expose themselves to a wide range of practices so that they can ultimately set up their own practice in this comprehensive style of care and ensure that family physicians are being used to their maximum ability within our community. While it is more complex to manage, I'm sure - I don't want to speak for the Nova Scotia Health Authority, but I'm sure it might be more complex to manage - I believe it is an indication that they are trying to expose themselves to a greater variety of health care settings, which is a very positive thing.

I cannot speak to the national licensure issue right now. Perhaps the Nova Scotia Health Authority colleagues would be more, but that would more be a licensure issue, which would be under the College of Physicians & Surgeons.

COLTON LEBLANC: I'll perhaps give Dr. Boutilier or somebody from the Nova Scotia Health Authority an opportunity to answer that licensure question. Although it's not within their purview of licensing, it is very important and is a critical aspect of recruiting. If a physician is not licensed in Nova Scotia, then regardless of the employer, they are unable to practise in Nova Scotia. I'd be interested to hear their point of view on this important question.

NICOLE BOUTILIER: Certainly, it's a question that has come up not only for Atlantic but national - should there be a national licensure system? As you said, we aren't responsible for the licensing of physicians, but it does impact us when folks have licence issues.

Generally, the collaborative nature of the licensing bodies across Canada is very collaborative and information-sharing. They do have a separate application process and fees and things like that, so that may be a stumbling block within Atlantic Canada for locums. We do have a lot of locums that we utilize on a regular basis from New Brunswick and P.E.I. mostly, and people who maintain licences in more than one province because they've either lived there or they come from that area and they go there to vacation, and things like that. We often see people coming home to Nova Scotia for locums with licences from other places.

It would be a convenience but we do manage quite well with the current situation.

COLTON LEBLANC: I'll pass over the remainder of the time to Ms. Adams.

BARBARA ADAMS: I'm very happy to have you all here today and I'm going to say something that I say every time we have a legislative session. I represent Cole Harbour-Eastern Passage, which is the only constituency in Nova Scotia that doesn't have a single family doctor, we have no collaborative health centre - despite there being over 80 - and we have no local mental health services. The movement of those mental health services from Dartmouth to Cole Harbour has actually made it harder for my constituents to get to it.

I had started a physician recruitment committee years ago, and we had been successful in getting a clinical nurse practitioner, but that's not a collaborative health centre, still not a physician, and there are still no mental health services. The committee had gotten a small grant to do the Department of Communities, Culture and Heritage Culture Innovation Fund, and we were working on that, and in the process I was in negotiations with a physician from Britain who was interested in possibly coming to our community. I wrote to the NSHA and the Department of Health and Wellness and asked for help in navigating the process of bringing a physician to our community.

My question is to Ms. Philopoulos, because she was part of the people who responded to me May 21st, and basically the letter in a nutshell said they've accepted physicians in Forest Hills Family Practice, which is not in my constituency, as well as

physicians in Dartmouth, which again is not in my constituency. The letter indicated that the physician that I was trying to recruit and negotiate with was actually - you guys wanted her to be in Dartmouth.

When I got elected, my first meeting was with Dr. Rick Gibson, who at the time was responsible for physician recruitment in my area, and he gave me a letter that said, yes, you need a physician there, you don't have one, you can do that.

Given that we have no physicians here and no collaborative health centre, I'm wondering if you were aware that the two areas that you talked about, Dartmouth and Forest Hills, are not in my constituency. I know how the Minister of Health and Wellness has responded to my question, which he said, we're leaving it that way. Not one of my constituents are happy with that.

I'm wondering if you can respond to the letter that you wrote, and to tell me in plain language: Is my constituency worthy of having a collaborative health centre and local mental health services and a family doctor? If so, what has the Department of Health and Wellness and the NSHA done to help with that?

KATRINA PHILOPOULOS: I think what I can share is that Eastern Passage Family Practice is part of a broader collaborative care team that's based out of Pleasant Street Medical Group. That was the information that was shared with you, I believe, in the letter that you're referring to. I think I can also say that the stakeholders that were involved in the letter were those around primary care, and as you mentioned also in your remarks, Dr. Gibson has had a few discussions with you about planning for primary care services in your community.

As part of that identification of service, there is a full-time nurse practitioner that is available to service the primary care needs of Eastern Passage residents, and that feeds into the Pleasant Street Medical Group as well. A provider would basically allow for coverage for patients during scheduled and unscheduled absences to ensure that continued care for patients of the practice.

The additional piece is that Pleasant Street Medical Group did have a new physician who arrived in January 2021 who is accepting new patients, and one of the pieces that we had suggested at the time was around directing constituents to put their names on the registry to ensure that they could be securing a provider.

BARBARA ADAMS: You basically restated what was in the letter, but my question was, Dartmouth is not in my constituency - South Woodside is. It is not in my constituency. There are only 51 constituencies. We are the only one without a doctor, and as much as we love our clinical nurse practitioner, she is not a physician. My constituents want to have a physician here. Over 2,000 of them signed a petition, wanting a collaborative health centre so that we can have those additional services like a psychologist or a social worker or physiotherapy. We have no mental health services.

My question to you is: Why is my constituency the only one that doesn't seem to be given the same priority as every other constituency? We have the same travel issue - we can't take a bus directly to Cole Harbour, there are a lot of seniors who have travel issues. I don't understand why we are the only constituency that does not have a doctor, collaborative health centre, or any local mental health services - and for that matter, we have no government services here. We have no community services. The only government services we have provincially are my office, the unemployment office, and our liquor store. The question is, with the time that I have left: Why are we the only one that doesn't seem to be given this service?

KATRINA PHILOPOULOS: I guess from our perspective, I believe that the Nova Scotia Health Authority's health planning team has worked with you to identify the solutions. We work with all areas in trying to find the best solutions, so this was the solution that was offered at this time. I can't speak to the other health-related pieces that are not available, but certainly this was the solution that was offered with respect to a nurse practitioner.

Remember, too, that when we're trying to tie in collaborative care and opportunities for care, it is through a number of different providers, and so we're really trying to focus on what's the best fit for Nova Scotians at any given time. Certainly, the nurse practitioner does have the ability to refer to specialty services when required.

THE CHAIR: Order. The time has elapsed for the PC caucus. We move on now to the NDP caucus and Susan Leblanc.

SUSAN LEBLANC: I'd like to pick up a little bit on what we're talking about here, but more to do with the Need a Family Practice registry. According to Statistics Canada, in 2016, only 723,000 Nova Scotians over the age of 12 reported that they were attached to a regular health provider. That left approximately 100,000 individuals without primary care. That statistic points to a possible irregularity with what the registry is saying right now - I believe the number is 69,000 at the moment on the registry.

People in my district of Dartmouth North have long been saying that we know for sure that there are many people who aren't on the registry for a bunch of different reasons. Mostly to do with being marginalized, and also - I know it sounds amazing, but at this point it's still not really realizing that there is a registry. We've done a number of things with the Nova Scotia Health Authority to improve the awareness of the registry but I think that if that's happening in one location in the province, it's probably happening in many locations. People don't trust the registry, people don't trust the internet - there are all kinds of things.

I'm wondering, given that discrepancy between 100,000 not connected to a health care provider and 69,000 on the registry, if the Nova Scotia Health Authority has any processes for measuring what the true need of primary care is in Nova Scotia outside the registry?

NICOLE BOUTILIER: I think that by having the registry, we have some sense of the need in the province. Obviously, not everyone's always looking for a physician, either, even when they don't have one.

It would be impossible, I think, to voluntarily get people to sign up for that service if they didn't want it. As you say, there might be other reasons why they're not. I think the last Canadian numbers that we have based on surveys show that when you look at Canadians who are aged 12 or over, about 12.7 per cent of Canadians said they didn't have a doctor. Numbers were as high as 25 per cent in places like Quebec and 18 per cent in Saskatchewan and Alberta. In Nova Scotia, it sits at around 7 per cent of the population.

We do have a sense of where we are. Do we have an exact number? No, but we have numbers that we follow to make sure we're responding to the population needs, and we do know that the Nova Scotia population is growing, so that changes what we will need to provide in terms of services.

[1:45 p.m.]

SUSAN LEBLANC: Thanks for that answer. I hear that there's lots of he-said/she-said about the numbers and that kind of thing, but nonetheless, when you're making decisions about where collaborative care centres go or where a vacancy is listed and that kind of thing, or where you're putting your recruitment efforts, it's worrying.

I totally get that people in urban HRM have more access in general to physicians than people in rural areas, and that's really what we're talking about here. Nonetheless, I think that in certain more marginalized areas within HRM - physically marginalized and otherwise marginalized - I think there is a need to look at other metrics.

In Nova Scotia, we have currently 160 physician vacancies. I'm wondering if you can tell us roughly what the number of vacancies would be if it included pending retirements, let's just say in the next three years. I know whenever I talk to anyone at Nova Scotia Health Authority about this, they say: these are the numbers, we can't speak to who is going to retire, but we kind of have an idea of some people who are planning to retire in the next three years. I'm wondering if you could talk about that and what the outlook is for the next three years.

NICOLE BOUTILIER: I really do wish we had a crystal ball about the three years, because we actually don't have that information. We do attempt to get it from physicians, but often physicians' plans change, and one of the things that happens often with physicians is that while they may leave one part of their practice as they get to a certain stage in their practice, they often continue to contribute to the system in other ways. Whether it's remaining as an assistant in the operating room, or doing shifts in emergency, or they may take on locum responsibilities throughout the province, many of them maintain their licence for many years after they "retire" from a practice. It is very much a moving target.

We do know that we have a number of doctors of retirement age, and that number is like any other segment of the workforce now, with baby boomers and retirements and that. One thing we have experienced with COVID is that a number of people who had been considering retirement - who we did have in the queue as going to leave sooner - actually stayed on throughout the pandemic, staying longer than they do. It's often a very common thing that a physician doesn't necessarily retire when they, say, stop practising in their office. They move on to other things in the system.

We don't have a three-year forecast on that. Physicians aren't obligated to share that information with us. We do try to get it from numerous sources, and if they are generous enough to share with us their plans, then we definitely plan for that.

SUSAN LEBLANC: In the last number of years, there has been a 127 per cent increase in the number of people visiting emergency departments who aren't attached to primary care providers. That's according to a freedom of information request filed by our office. The problem is particularly acute in certain parts of the province. For instance, in the Northern Zone, the number increased by 230 per cent over the same period.

Of course, like so many health and health system issues, the problems compound. People don't have access to primary care, they're more likely to have worse health problems that reach an acute or emergency stage by the time they go to an emergency room. Once they get there, it's more likely to be overcrowded with people seeking that same type of care, which obviously may be better provided in a primary care situation.

I'm wondering if you can speak generally - and again I think this is for Dr. Boutilier, but feel free to pass it on if you like - about the impact of the lack of access to primary care on our emergency departments.

NICOLE BOUTILIER: We actually have the Northern Zone Executive Medical Director on here, so I will ask him to speak to the Northern Zone in a minute. But in general, we have created numerous primary access clinics across the province for people who are unaffiliated to direct some traffic away from the emergency room. I could list them all but there are a lot. We have clinicians who are working with us in those clinics to provide that service for the local people without physicians.

We also, as I mentioned earlier, have a virtual care project that's going on in two zones. I will ask Aaron to speak to this but they have recently started a virtual care emergency room project as well in the Northern Zone.

THE CHAIR: Dr. Smith.

DR. AARON SMITH: When we have areas where we are struggling to fill family medicine vacancies - for example, my own area in the Northern Zone - we do tend to see more people presenting for care at our emergency departments. This is problematic because

it's not ideal in terms of people's primary care needs. It's also difficult because it increases traffic and wait times in our emergency departments.

Of course, we are continuing with our active recruitment strategy to try to fill these vacancies as much as possible, and fill them very thoughtfully in terms of supportive practices, collaborative models, et cetera. While we're doing that, though, we remain acutely aware that we have people on the Need a Family Practice registry who may not feel they can access the care they need in a timely manner. As Dr. Boutilier has pointed out, we have tried to approach that with an innovative mindset, leveraging resources that we have to try to improve people's access.

One of them certainly has been the establishment of our primary care clinics across the province, including the Northern Zone, whereby people on the Need a Family Practice registry can access primary care in these clinics, hopefully thereby addressing the needs but also making them feel they don't need to go to the emergency department to get these needs dealt with. That can be for preliminary visits, for follow-up, for referrals - the full suite of family practice services.

The other one that I think is really exciting - not that the other isn't, of course - is our virtual care primary care approach, whereby people in the Northern Zone as part of our pilot but also in the Western Zone who are enrolled in the program can access primary care services virtually provided by Nova Scotia physicians, and if their needs cannot be dealt with virtually, they are seen in person, in most cases in the communities or very close to the communities where they're from.

Hopefully, using these two approaches will really help to provide the services people need while they're on that Need a Family Practice registry. If it is true primary care that they're looking for, they can hopefully access that within the community - in some cases, within their own homes.

The other part that Dr. Boutilier mentioned is our virtual care ED project. I will say that is in its infancy, but again, looking at how we can provide services that have traditionally necessitated people walking through the door of emergency departments. How we can leverage our virtual care approach and technology to see how we can come out to more where patients are and try to really streamline that approach.

SUSAN LEBLANC: According to walk-in doctors in Dartmouth, virtual billing codes are not available for physicians who only are in walk-in clinics, who are unattached to patients. I've made that more complicated. My understanding is that if a physician is working in a walk-in clinic and is unattached to a regular panel of patients, they can't do virtual billing. I've heard from the Minister of Health and Wellness that this is simply not true but then I heard from the doctors that it is absolutely true. I'm wondering if anyone can clarify that, first of all. Is that correct, what I'm asserting?

NICOLE BOUTILIER: Virtual care, walk-in clinics - it's a complicated question and there's not a straightforward answer. We did have some of our clinics during the pandemic where the virtual care policies had started providing care virtually for us as part of what we stood up in times of COVID. It isn't a straightforward answer.

In general, the policy for virtual care is still evolving. There's an advisory council being started very soon - within the next few months - to look at issues and perhaps gaps and improvements that can be made while the policy is being fine tuned. However, there have been differences between walk-in clinics and certain walk-in clinics based on things that were happening because of the pandemic, and as you know, most of the virtual care we had did evolve during the pandemic.

SUSAN LEBLANC: It's complicated, yes. If there are barriers in the current system where people who don't have family doctors have an added disadvantage to accessing a family doctor or a care provider though virtual care, can I take from your answer that that issue - if it is in fact a policy or if it's just a misunderstanding or whatever it is - will be looked at by this working group you've referenced?

NICOLE BOUTILIER: Yes, it will be multi-stakeholder working groups, so that feedback and evaluation frameworks and things like that can be developed to strengthen virtual care throughout the province.

SUSAN LEBLANC: As we've heard from a number of people today, community collaborative health centres can be an excellent model of care in terms of providing truly community-based and community-driven primary care. Is there a consideration of expanding the support for this model and how that could tie into recruitment work? A (b) part to that is in terms of not just recruitment work, but also residency programs.

Is there any discussion about collaborative care centres being placed in communities, and then having residency programs attached to make them work better or to increase their capacity?

THE CHAIR: Is that for Dr. Anderson?

SUSAN LEBLANC: Either Dr. Boutilier or Dr. Anderson.

THE CHAIR: Put your hand up if you want to answer.

DAVID ANDERSON: Maybe I'll give Dr. Boutilier a break here and start. Madam Leblanc, I agree with the premise that collaborative care models are an excellent opportunity for the training of our medical schools and residents and we and Nova Scotia Health Authority are strongly supportive of interdisciplinary teams as a great model for looking after the care needs of the people of Nova Scotia.

I would ask if Dr. Stringer could comment on the models of training of our residents in these types of settings.

KATHERINE STRINGER: I'll just reiterate Dr. Anderson's statement that absolutely, wherever possible, we want to expose our residents to this type of training - recognizing that that is the gold standard of care after graduation.

I think actually the best person to answer this question is probably Dr. Conyers, because he both works and teaches in this context and has other clinics within the Valley site - both new ones that are just about to begin and existing ones that have our residents in this context. So perhaps if I can ask him to comment on that experience.

DR. ROOP CONYERS: Let me say I completely agree that collaborative care is certainly an excellent model, both in terms of how we train our residents and in terms of the kinds of practices our graduates are going into. From a training perspective, we are very deliberate here in the Annapolis Valley to make sure our residents are trained in an interdisciplinary collaborative approach - both with family physicians and their specialty colleagues and our allied health colleagues.

[2:00 p.m.]

Our residents are actually placed in separate communities in group practices that work in teams, that deliver care to community. What's interesting from that approach is that as they enter practice, our graduates are actually seeking that. They're seeking that kind of environment to go and practise in.

You're quite right. It lends itself to a model in communities. Partly that team approach allows and supports recruitment. Our residents throughout their training work in groups of teams that support each other, and they recognize that there is benefit to them in practice in primary care. When they graduate, they want to go to a community that has that team approach, because it not only provides good care for our citizens, but it also provides good work-life balance for our physicians.

I think the two go well hand-in-hand - both from a training perspective and in the kinds of practice environments we will at least have available to graduates.

THE CHAIR: The time has elapsed for the NDP caucus. We move on now to the Liberal caucus. The Honourable Leo Glavine is starting for us, I believe?

HON. LEO GLAVINE: I'm pleased to have the overview today on Dalhousie Medical School, and certainly welcome all of the doctor leaders here today as witnesses.

I wanted to start off with the fact that Dalhousie Medical School has increased the number of physicians in the school. At least I'm aware of 16 positions, and maybe that is the total number. Is this a trend happening across the country, or are we looking at the

needs in our province and working to address that? Perhaps Dean Anderson, who I've had the pleasure of working with, could respond.

DAVID ANDERSON: Yes, Dalhousie Medical School has increased in size, both in undergraduate medical students and in residency training positions. Just to speak to each, we've increased our undergraduate numbers by 16 per year - this is a total of 64 new students over a four-year period. At a residency training level, we've increased by 25 per year. Both of these changes have occurred in the last two or three years.

These changes were made to address the needs of our province and particular concerns about doctor shortages, so this is a very significant injection to allow us to produce more physicians in our region, again recognizing the importance of Dalhousie graduates in the physician numbers in our province.

It has not been a national trend. We are one of the few schools in the country that has seen a recent increase in medical student and residency training numbers. This is under discussion I know in other provinces, but it has been unique for Nova Scotia that undergraduate and graduate position numbers have increased in the last five years.

LEO GLAVINE: In terms of the clerkship, that again has been brought forward in the last few years. Do we have any early observations or results again for having those potential graduates looking at the communities in where their clerkship is taking place?

DAVID ANDERSON: Our programs in Nova Scotia are just two years old, so those medical students are in third year. They're working their way through their residency selection and training processes, so we don't have Nova Scotia specific data. We do know, however from other jurisdictions, including New Brunswick, that students who go through this model of education where they work and train in the community setting are highly likely to enter what we would term generalist areas of residency training which they experience in the community setting - disciplines such as family medicine - and they are more likely to return to a community setting upon graduation than students who are trained in the more traditional rotational model.

I think it is also worth noting that the students receive an outstanding educational experience from our physicians who are working in communities around the province. They are embraced by the communities. The students have a tremendous experience, and it does give them the option - some of them who grew up in urban areas - to see what it's like to live in a smaller community for the first time. That is impactful in decision-making around what they ultimately will choose to do.

The student response has been very favourable and in talking to them, they appreciate greatly the value of being able to work in a community setting as they do under the direction of the teams in this program.

LEO GLAVINE: I guess perhaps anyone could make comments on or address my next question. I know the African and Indigenous communities have certainly been wanting to have physicians and other medical practitioners with cultural sensitivity as part of family medicine in their communities. I was wondering if you could give the panel here an idea of what progress has been made in that area.

DAVID ANDERSON: I can start with training. As I briefly mentioned, we do have pathways for admission for two priority groups in Nova Scotia that have been historically disadvantaged by their admission to medical school. Those are students of African Nova Scotian and Indigenous backgrounds.

In brief, the way these pathways work is that if students of African or Indigenous heritage apply to medical school and they meet the minimal eligibility criteria, they are offered a seat in our medical school. They do not compete with the broader community of applicants who do not identify as being of either African or Indigenous heritage. As a result of that, we have seen over the past five years 25 students of either African Nova Scotian or Indigenous heritage enter the medical school training.

Just compared to historical reference, that is an exponential increase in students from those backgrounds. We would agree with Minister Glavine about the importance that our medical graduates represent the communities that we serve in this province and of the need for our African and Indigenous communities to have physician access to health care providers who look like them and have a similar cultural upbringing. We are seeing more of these students as they move into residency and graduate and move through the system. We're very pleased to be able to increase the numbers of students from diverse backgrounds.

LEO GLAVINE: Just to switch to an area that certainly I became aware of when I was minister - indeed, in a little community like Neils Harbour and seeing oncology work from the specialist in Sydney working with patients in the 10-bed Buchanan Memorial Community Health Centre in Neils Harbour - virtual care has been around for some time.

I was wondering in terms of the pilot in the Western Zone, what are some of the early indicators of its success and for us to certainly commit to maintaining that service, especially for primary care?

ROOP CONYERS: I think I might actually defer to Dr. Boutilier on this. She probably has far more knowledge about the virtual care program here in the Western Zone.

NICOLE BOUTILIER: It's been rolling out. We have the Western Zone and Northern Zone going on concurrently and we're intaking invitations to about 2,000 people every week since the pilot started in mid-May, and I think we're up over 13,000 people who have been invited to sign up for the program already. We've had close to 2,500 people sign up, and consults are happening regularly across the province with virtual care providers.

Obviously, we have the people who are on the list whom we're targeting as the rollout goes on. The anecdotal responses that we're getting back from the patients is that they're very, very pleased with the service. They're getting seen in a timely way after they've requested a consult with a physician, and if they need to see someone in person, that's being facilitated as well.

I'm not sure if Dr. Smith wants to add anything from the Northern Zone on that, because he is part of the pilot there.

AARON SMITH: Certainly, I can. Again, I don't have specific information on the Western Zone pilot. I would imagine that the patient experience and the provider experience would be comparable. We have great data, really impressive data, about how quickly the team is enrolling and engaging patients going through. It's quite astounding, actually, how quickly they're progressing.

I think it needs to be said that this isn't just a question of using a Zoom platform or a Teams platform to connect the patient. This is using an entirely new platform and a medium to really streamline that process. We are really learning as we go and learning from our experience and iterating as we go along.

We certainly know that our providers have reported very high satisfaction with using the platform and the approach, which is great to hear. I can speak as a practising physician myself, and I'm sure this is a theme that rings true for all of you, that change is hard. As we fundamentally change how we connect and provide care with patients, that provider experience, I think, is extremely important to listen to. Certainly, we've had great feedback from the physicians and the nurse practitioners and other health professionals who are providing care under these virtual platforms.

The patients' experience anecdotally, as Dr. Boutilier has said, is extremely good. Patients have reported accessing high-quality care. They haven't reported any kind of major dissatisfaction with the virtual approach, at least to my eyes in the reports I've gotten. They certainly have been very pleased with the ability to convert from virtual to in-person, especially very close by to the communities where they're accessing from.

I think that this certainly represents a very innovative and very promising path forward for how we continue to provide high-quality care for Nova Scotians.

[2:15 p.m.]

LEO GLAVINE: In terms of training - and probably Dean Anderson or somebody else would like to comment - we know that doctors are well-trained as clinicians for diagnostic work. I'm wondering in terms of developing population health to a greater degree. We know the incidence of chronic disease in the province, which unfortunately we rate first, second, or third in many of those in the country. Is there a component around preventive medicine or disease prevention in the training now of a 21st century doctor?

DAVID ANDERSON: Absolutely is the answer to that. It is very important for us that physicians are trained in all aspects of the work that they are going to face as they enter practice, and the importance of disease prevention is a very important one to them, as appropriately so. It's an important one for the patients that we serve.

As part of our medical school curriculum - as early as the first year of medical school - students are exposed to issues around major risk factors for disease, social determinants of health, specific important clinical parameters that put the patients and the public at increased risk of adverse health outcomes that they need to be well aware of. Nutrition and lifestyle factors are things that are addressed early on in medical school.

I would ask Dr. Stringer to maybe comment specifically about in our family medicine residency training program how that education permeates throughout the continuum, including when graduates enter residency training.

KATHERINE STRINGER: Absolutely. In Family Medicine we continue to build on this approach, and I would say that this is one of the things that is at the very heart of Family Medicine at present. Exposing our residents to both what we would call our academic as well as our clinical curriculum, we deal with preventive care on a regular basis both in a didactic teaching curriculum, as well as obviously their exposure within family physicians' offices.

The longer we can actually centre our training within a family physician's practice, the better. Specifically we have some of our training sites, in the Annapolis Valley we included a longitudinal integrated residency, which is very similar to the Longitudinal Integrated Clerkship referred to by Dr. Anderson. The beauty of this is that it exposes our residents to that longitudinal aspect of care where they can start to see the effect of their preventative care that they have engaged in discussion with patients and begin to see the results thereof.

We very much focus on the aspects of preventive care and the social determinants of health within that exposure to family medicine practices, and we have extended the amount of time that our residents are exposed to this context.

LEO GLAVINE: I thank all the doctors who have participated in the questions that I've asked very quickly.

Dean Anderson, I know your desire for excellent outcomes in the training of our next generation of doctors, starting with Dr. Marrie and now under your leadership. How are we positioned in terms of our students on the national exams and the certification that they go through? I do hear good things, but if you could give us at least a quick comment, please.

DAVID ANDERSON: I would agree with your sentiments, Minister Glavine. Our student scores are rated very highly, both in the licensing exams that are taken on a national

basis, also when our students move into residency training programs across the country, they are incredibly favourably received because of the training programs that they've received while they're at Dalhousie. We get both objective feedback from exam results, along with verbal feedback or written feedback about their performance from people who take them from medical school into training.

Our graduates are working all over the country in many different settings, from rural community practices to the tertiary care, quaternary care centres and their activities. They're capable of entering training programs in any or all of these areas and have been excelling.

THE CHAIR: We're going to move on to the next round of questioning. We will start with the PC for seven minutes per caucus. Ms. Adams.

BARBARA ADAMS: We've talked a lot about the who, how, where, when, and why of what we're doing, but I'm most interested in what all of these initiatives have resulted in.

I'm a little confused, because I'm looking at the NSHA's By the Numbers, and for 2019-20 it said that the number of licensed physicians in Nova Scotia was 2,287. That's fairly consistent over the last four years. However, the ones for 2020-21 say that there are 4,215 licensed physicians. Given that there are over 70,000 people at minimum in Nova Scotia without a family doctor, I find it hard to believe that we have 1,900, or almost double the number of physicians.

Is that an error in the Nova Scotia Health Authority By the Numbers online reporting? I don't know who would be the best person to answer that, someone from the NSHA perhaps - Dr. Boutilier?

NICOLE BOUTILIER: The numbers are total licensed physicians. There are people who would get credentialled or privileged with us who would be here for a short period of time as a locum and things like that as well. It would include all our privileged and credentialled physicians. Some of them are residents, of course, as well, that are working in the Nova Scotia health system. It's probably the college numbers that you're looking at, licensed physicians?

BARBARA ADAMS: I am going strictly by the NSHA By the Numbers - if you Google it, it should come straight up. For the last four years, it was 2,231 licensed physicians in 2017-18. Then it was 2,687. Then last year it was 2,287, and then this year it goes to 4,215. That is 1,900 more than the year before, and I find it inconceivable that that's an accurate number.

I'm going to leave it, but I'm going to ask if you can look into that because there's no way that we have 1,900 more licensed physicians - and if we do, what would be the full-time equivalent of those people?

On the same sheet, it says that the amount of family doctors was, and I'll go over the last five years: 844, then 1,093, then 1,197, then 1,112. Now this last year, it says 785. This is suggesting that there are 350 fewer family doctors now than a year ago. Is that also correct?

NICOLE BOUTILIER: It sounds like they're college numbers rather than our numbers, so I'll have to look at where that's coming on the Nova Scotia Health Authority site. Because I'm talking about licensed physicians.

BARBARA ADAMS: Right. My concern is that these numbers, there's no way that that first one is correct, I'm sure of that, because it says that physicians not family medicine - so specialists, essentially - went from 1,175 to 3,430. That's more than double. That's suggesting it's almost triple the number of specialists. I'm very concerned that these numbers are not accurate.

The question I have for the NSHA, and we've brought this up before, is you produce the wonderful Finding a Primary Care Provider graphics - I can't show it on screen. When they do this, they always list how many people found a doctor, how many people lost a doctor. Is it possible for the NSHA to put on there how many family doctors were hired in that month, and how many retired, died, or moved away or gave up their licence that month? Is it possible to start tracking that number?

NICOLE BOUTILIER: I can turn it over to Katrina to give you some of the more recent numbers that would impact that. We do have a manual way of looking at this. I will caution that some of the things that I mentioned earlier around people staying in the workforce, not just in their practice, is a very relevant thing that we have happening in Nova Scotia. In fact, most of the physicians that are taking part in the virtual care pilot are retired physicians. We haven't taken away from our primary care resources in order to run the virtual care proof of concept pilot.

KATRINA PHILOPOULOS: What I can share is that at Nova Scotia Health Authority, we are tracking the number of physicians that are starting on a monthly basis and reporting, and there is a little bit of lag sometimes, depending on the end of the month. For instance, for April, May, and June of 2021, we have recruited 19 physicians. Of the breakdown of that, there are eight family medicine physicians and 11 specialists. We further indicate which zones they are recruited to.

We also have been starting to track the number of physicians that are departing, and as Dr. Boutilier indicated, there are a lot of factors around that. Sometimes the information is not as timely. Sometimes the physicians will let us know they're leaving and they don't actually leave right away, and so they continue to practise.

For the departing physicians also, we recognize those who are retiring and those who are relocating out of province. For the last three months, we know that there are 20 physicians who are departing due to retirements or relocations.

BARBARA ADAMS: This is the very first time in four years where someone has actually said, we recruited 19 and 20 are leaving. I find it astounding - my father used to do this for a living. He ran MSI in this province, and he always knew how many doctors were working and how many were leaving.

I'm going to encourage both the Department of Health and Wellness and NSHA that they need to all work together so that every month, we know how many have come and how many have left, how many are full-time, how many are part-time FTEs.

The last question I have . . .

THE CHAIR: The time has elapsed for the PC caucus.

BARBARA ADAMS: No, I should have two minutes left.

THE CHAIR: It's 2:28 p.m. You started at 2:21 p.m. and you finish at 2:28 p.m.

BARBARA ADAMS: Oh, seven minutes. I apologize.

THE CHAIR: Next is the NDP caucus. Ms. Coombes, go ahead.

KENDRA COOMBES: I have a question around emergency room closures, and this might be for Dr. Boutilier, but if not, she can put it to anyone else.

Emergency room closures have increased steadily over the last number of years, as has the use of emergency rooms due to lack of primary physicians. Last year, they increased closures across the province again by 30 per cent, and I know that one of the contributing factors here is of course the doctor shortage and other staff who are able to keep hospitals open, especially the rural areas. I know the problem is really acute here in Cape Breton, for example.

I'm just wondering if you could talk about the issues and what is being done to address that.

NICOLE BOUTILIER: I want to start with the fact that every single one of our regional facilities are fully staffed and open, and with good staffing levels in terms of physicians. You spoke to the Cape Breton area, and I think that's one where when there are issues with staffing numbers, pulling in from some of the smaller, local emergency rooms really can help supplement the staffing in order to provide the emergency services that are needed.

[2:30 p.m.]

The second piece would be the first-class ambulance EHS system that we have in the province that works and redistributes their services with us working collaboratively so

that we service the whole province and ensure that emergency care is available no matter where you are, whether if their local emergency room is closed, and where they would provide the next available emergency room. Many of the smaller emergency rooms provide urgent care, and the regional centres would be a higher level, and of course the QEII would be our tertiary level of services.

I know that the different zones are working very hard around the province to come up with a stable system. Often in the summer, of course, there's a lot of transition. We have a lot of new residents coming into the system, we have people who are leaving the system, we have people who are also taking some much-needed time off, so our services in the summer tend to be more stretched than at other times during the year.

One of the mainstays of things that we try to do is to make sure that along every corridor in the province, there is access to emergency care. I can actually ask Dr. Smith to comment on how he's worked that out for this summer in the Northern Zone, where they are under some pressures.

AARON SMITH: Continuing with what Dr. Boutilier has mentioned, in the summer months especially at our smaller emergency departments and other centres providing more urgent, unplanned care, staffing and stability becomes a very large issue. In a lot of cases too, these centres are staffed and supported not just by emergency physicians but also by family physicians.

We have realized that access to care may not always be possible in all of our smaller, more rural sites offering these services, but we also realize it's important that care that is there is predictable and also is reasonably accessible. To that end, along the north shore, for example, in Northern Zone, we have planned and anticipated our closures between two of our more rural sites, mainly Tatamagouche and Pugwash, and have done our utmost to ensure that the closures are predictable and the other neighbouring site supports the health care needs while one of our sites is closed.

We believe this is a much better and more reasonable approach and will be making sure that we are communicating very actively with the residents along that corridor to ensure that they know just when those sites are closed and what the avenue is to access during those times.

THE CHAIR: Ms. Coombes, you have just under two minutes.

KENDRA COOMBES: That was quick. My point is, we don't want any of those hospitals experiencing closures for our residents. That was the point of my question: how we can stop those smaller hospitals from being closed.

I want to talk about the walk-in clinic in Sydney. It was recently under a threat of closure due to the cost of rent. I'm wondering if anyone from the Nova Scotia Health

Authority could provide clarity on the situation and what government is doing to ensure the walk-in clinic remains open.

NICOLE BOUTILIER: Many physicians across the province are in different relationships as a business. For many family doctors, it's actually a business that they run, and many physicians have overhead costs. That isn't something that the Nova Scotia Health Authority pays for. People have their own business arrangements.

One thing in the Sydney area which we've done: we have an unaffiliated patient clinic that we've recently added another 20 hours of support to, in order to increase access for unaffiliated patients. The local leadership has been working with the physicians around different possibilities as they look to transition. There's a variety of reasons why practices change, and they've been working through some of the issues with that.

THE CHAIR: The time has elapsed for the NDP. We move on now to the Liberal caucus. Mr. Horne, go ahead.

BILL HORNE: I'm just so impressed with what we're discussing today, and that I have a place to play in this. I'll ask a number of questions that you may have answered some, but I'd like you to maybe consider other issues with the answer.

The first one is: How is the practice of family medicine changing? We have discussed some of those issues. How are you adjusting and aligning the medical programming to support this? Probably to Dr. Stringer.

KATHERINE STRINGER: You are correct: the practice of family medicine is changing. The old model of the one family physician serving a community entirely on their own is no longer a model that is serving our population well. It's changing to be more of a team-based approach, as is evident with our collaborative clinics.

What we are doing in our educational programs is making sure that we train our physicians in this model, so focusing on teamwork - the family physician is often the leader of this team - and focusing on communication within a team. This model really promotes the continuity of care and communication across various settings and domains in which clinical care is offered - for example, a continuity of care between the clinic, the hospital, the long-term care unit, et cetera.

We very much focus on all of these competencies within our residence to ensure that they are then able to practise. I think as Dr. Conyers alluded to earlier, our graduates are indicating to us that this is how they want to practise as well.

The National College of Family Physicians of Canada every year does a survey of graduating residents. We receive data that is both our Dalhousie aggregate data as well as the national data. In that survey, 85 per cent of our graduating family doctors at Dalhousie indicated that they were somewhat or highly likely to be practising in group settings and to

be practising across multiple domains of care, which is exactly what we are wanting and what we think will serve our population base and what we are preparing our graduates for.

BILL HORNE: On another hand, can you do a deeper dive on the Practice Ready Assessment Program, and how does it operate to produce better doctors?

THE CHAIR: Dr. Stringer, I'm assuming?

BILL HORNE: I think so, but I'm not sure.

THE CHAIR: Who would like to take that one? Just raise your hand. Dr. Anderson, go ahead.

DAVID ANDERSON: I'll just start to say that this is an important program, and again one of the things of a medical school is the need not only to train undergraduate students and residents who are training to be specialists in family medicine and other disciplines, but also to assist with the training of physicians who have completed practice, and in this case physicians who do not have a path to licensure as international medical graduates in our province.

I would ask Dr. Stringer, whose department leads this program, to give us more details.

KATHERINE STRINGER: Thank you, Dr. Anderson - you are correct. This is a program that is offered for international medical graduates who would otherwise not have access to licensure within Nova Scotia. It began towards the end of 2018 and what we do every year is, candidates will first apply to the College of Physicians and Surgeons of Nova Scotia, and if deemed appropriate, they will then be recommended to our program. We worked very closely with the Department of Health and Wellness and Nova Scotia Health Authority in developing this program and in the entire process of this program.

To date now, we have put through three cohorts of five candidates. This happens every six months. As part of that process, each candidate is assisted by a family physician out in our communities to ensure these physicians entering Nova Scotia have the appropriate skills and knowledge to be able to practise family medicine appropriately for our population.

I'm pleased to say that of the 15 candidates that were assisted, 12 of those have been written into full licensure within the province, back to the college. Of those, eight are presently in return of service contracts across the province in communities that are desperately in need of family doctors. Four, hopefully after their licence has been issued at the end of this month, will be doing the same. We've recently offered five new candidates positions in this program.

It is a program that is offered in many provinces. We are one of many that offer this program and another source of recruitment for family physicians in this province.

THE CHAIR: I think you only have about 30 seconds, Mr. Horne. Maybe just say a nice comment and we can end the questioning.

BILL HORNE: Sure. It's been a privilege for me to be an MLA and to be introduced to a lot of the medical problems that we have in Nova Scotia. It does seem to be continuing, but it is improving at every juncture, I'm sure. I would like to talk a little bit about the immigration of students and/or doctors, maybe just a quick number of how many are happening, and that may go to the Nova Scotia Health Authority.

THE CHAIR: I'm afraid time has elapsed. Maybe I could ask the witnesses if they have any closing remarks. They can include that answer in their closing remarks, maybe.

Dr. Anderson or Dr. Boutilier? Would you like to end it with some closing remarks?

NICOLE BOUTILIER: I was just going to say that perhaps Katrina could speak to the immigration piece in the closing remarks.

KATRINA PHILOPOULOS: I think from an immigration perspective, we've had some good success for physician recruitment for foreign-trained physicians. About 20 per cent of our recruitment efforts are around recruitment of internationally trained physicians to Nova Scotia. This has been really in partnership and success with the Nova Scotia Office of Immigration and Population Growth with respect to offering physician-entry pathways, which were the first of their kind across the country - really innovative and really has allowed us to do some good work.

Previous to 2018, we had maybe three international recruits, so we've now been pretty stable in having about 25, 26 - I think this last year we had 27 internationally foreign-trained physicians.

I can also share that during COVID, when all international and global travel was banned, we were also successful in bringing physicians to Nova Scotia, which was not an easy feat. Our recruiters worked with our federal partners to understand the acts and the changes in Public Health measures, and to identify individual ways forward for each physician recruit. We had our first physician come to us during a global pandemic in May of 2020, which really is quite outstanding when you think about that.

We also rallied with our partners in our communities and really had a number of communities support us, as well as the recruiters step up in helping to support physicians and their families coming here. Imagine coming to a new place, a new country, not knowing anyone, and having to be in quarantine. We leveraged our partnerships with our communities in helping to ensure that groceries were delivered, that transportation was arranged, that appropriate accommodations were identified, that there are baskets for their

kids of toys and things to entertain them during that 14 days. Trying to identify things and think about someone that we may not have known or have had a relationship with and what they could need during this time was imperative.

[2:45 p.m.]

Our recruiters really stepped up to the role of immigration, and I think through that, we also saw we engage and continue to engage with physicians who are interested in Nova Scotia and coming to practise here, and by way of virtual methods. We have people who have come without actually coming here to visit, so that opportunity has really served us well.

THE CHAIR: That's very encouraging, thank you very much. Dr. Anderson, would you like a few moments as well?

DAVID ANDERSON: I just want to thank the committee for their interest and their questions today. I want to thank my colleagues for coming in helping address the questions and the concerns that you've raised. We are passionate about the importance of educating the health care providers of tomorrow in our province, and this is the work we do, and we are proud of it and we very much value the feedback from all as to how we could be doing a better job here.

We highly value the collaborative opportunities that we have with Nova Scotia Health Authority, the IWK, and government to do a better job at training. This is a team sport, and we cannot do it without the tremendous success of our colleagues.

Finally, I'm almost astounded that we've had a two-hour meeting on health and I don't think the word COVID has been mentioned once. (Laughter) I would like to close just by acknowledging and thanking all of the health care professionals in our province, our health authorities and our Public Health officials for all that they've done to keep our province one of the safest places in the world over the last year and a half - just want to acknowledge that here today. Thank you very much.

THE CHAIR: I couldn't agree with you more. It has been an amazing collaboration and a show of how our health system worked well together as one team to fight COVID and to bring us these amazing results that we have. I thank everybody who is in health services today that joined us, and if I could ask you to leave so we can do some committee business. Thank you again for appearing.

For committee business, we're starting with the organizational chart of the Department of Health and Wellness. This was forwarded to members on July 8th and again this morning. I'm assuming everybody received it and there are no questions or discussion? Thank you.

The second item on the committee business is a letter from the Minister of Education and Early Childhood Development regarding COVID and early childhood educators: response to letter from committee to the Minister of EECD and Department of Health and Wellness after the May 11th meeting. This was forwarded to members on June 16th and again this morning. Any discussion? I see none.

I move on to the next items. There's an email from Theresa Cunningham regarding Strongest Families Institute. This was forwarded to members on June 17th and again this morning. Any comments or discussion? I see none.

We can move on to any other business. The next meeting will be I think August 17th from 1:00 p.m. to 3:00 p.m. via video conferencing, and the witnesses will be Dr. Robert Strang, Chief Medical Officer of Health; Department of Health and Wellness; and Dr. Brendan Carr, President and CAO of the Nova Scotia Health Authority, regarding the ongoing COVID-19 response.

Ms. Leblanc, I see your hand. Go ahead.

SUSAN LEBLANC: Yesterday in Public Accounts Committee, the committee agreed to move forward with in-person meetings again. I'm wondering if we could have a quick discussion about the potential of that, given we are in Phase 4 of reopening and things seem to be going well.

THE CHAIR: Yes, 100 per cent. I'm looking forward to it personally, and I believe my colleagues - as long as we're in good standing with health and everything can open up, we would love to be back in person.

SUSAN LEBLANC: Do we need to make a motion about it?

THE CHAIR: Would you like to make a motion?

SUSAN LEBLANC: Sure, I'll make a motion that going forward, we or whoever is around this table meets in person, barring any advice to the contrary from Public Health.

COLTON LEBLANC: I second that, Madam Chair.

THE CHAIR: All those in favour? Contrary minded? Thank you.

The motion is carried.

Thank you for bringing that up. I look forward to that - again, whoever is going to be on that Health Committee.

I thank you all. This has been a very informative session.

The meeting is adjourned.

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