HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

VETERANS AFFAIRS

Tuesday, June 15, 2021

Via Video Conference

Veteran Physician Assistants' Role in the Health Care System

Printed and Published by Nova Scotia Hansard Reporting Services

VETERANS AFFAIRS COMMITTEE

Rafah DiCostanzo (Chair)
Bill Horne
Hon. Leo Glavine
Hon. Gordon Wilson
Hon. Ben Jessome (Vice-Chair)
Kim Masland
Murray Ryan
Lisa Roberts
Claudia Chender

[Hon. Gordon Wilson was replaced by Hon. Suzanne Lohnes-Croft.]
[Hon. Ben Jessome was replaced by Hon. Chuck Porter.]
[Kim Masland was replaced by Barbara Adams.]

In Attendance:

Heather Hoddinott
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Canadian Association of Physician Assistants

Peter Thibeault
Director, Nova Scotia

Erin Sephton
Alternate Director, Nova Scotia

College of Physicians & Surgeons of Nova Scotia

Dr. D.A. (Gus) Grant
Registrar & CEO

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, JUNE 15, 2021

STANDING COMMITTEE ON VETERANS AFFAIRS

2:04 P.M.

CHAIR
Rafah DiCostanzo

VICE-CHAIR
Bill Horne

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

I would like to do a couple of housekeeping items. The witnesses and all the MLAs are to keep their videos on all during the meeting. Keep your mics on mute until I call your name. Please wait for me to call your name. That's for Hansard's purposes. Also, for the witnesses, if you want to speak, maybe just raise your hand on the side so I know you want to speak. The MLAs should say who their question is directed to. Either way will work for me, if you could help me do that.

On today's agenda, we have officials from the Canadian Association of Physician Assistants and the College of Physicians & Surgeons of Nova Scotia. The topic we're discussing is Veteran Physician Assistants' Role in the Health Care System.

I would like to first ask the members to introduce themselves, starting with Mr. Bill Horne.

[The committee members introduced themselves.]

THE CHAIR: Now I'd like to introduce the witnesses, if we can start with Mr. Peter Thibeault.

[The witnesses introduced themselves.]

THE CHAIR: I just want to remind everybody to check your cellphones to make sure they're on Vibrate or off. Then we can start with the opening remarks. I believe Mr. Thibeault is giving us the opening remarks today.

PETER THIBEAULT: Good afternoon, everybody. My name is Peter Thibeault. I recently retired from the Canadian Armed Forces after 32 years. I served in a variety of postings on multiple deployments across Canada and around the world. I am currently employed as a physician assistant (PA), working for Remote Emergency Medical Services Inc., which is REMSI, which is technically where I am right now in northern Ontario.

Before I continue, I am on call, so if there is an emergency in the gold mine, I will have to disappear very quickly and go to the medical clinic. Hopefully, nothing will happen. It's a pretty safe place up here.

I have called Nova Scotia home since the age of five, growing up in Barrington Passage on Nova Scotia's beautiful South Shore. Since 2010, I've been a certified physician assistant and have extensive medical experience, along with teaching and mentoring the next generation of military PAs who are based in Nova Scotia.

PAs are advanced practice clinicians trained in a medical model and practice medicine with a degree of autonomy negotiated with a supervisory position to provide primary, acute, and specialty care in all types of settings. We discuss illnesses, develop and manage treatment plans, prescribe medication, perform procedures, act as a first assistant in surgery, and much more.

Today, there are more than 700 certified PAs working across Canada to deliver seamless care in a cost-effective manner. In Nova Scotia, core access to family doctors is consistently perceived to be the greater concern in a province with close to 56,000 Nova Scotians on the Need a Family Practice Registry.

In addition, the Province struggles to address closures of rural emergency departments, challenges in recruiting and retaining doctors, and hundreds of Nova Scotians dying while they await surgery. Given this context, we know that PAs can help as we are ideally situated to make immediate contribution and help improve access to care, enhance team-based care, reduce wait times and make the working life of physicians much more manageable.

There are more than 30 military PAs who live here in Nova Scotia. Most, if not all, would prefer to stay in Nova Scotia and continue practising in the public health system,

unless they retire from the military. I totally agree, being in Ontario right now. Yet, in the meantime, we need training opportunities for maintenance and competency readiness skills. I'll elaborate on that in a second.

By allowing military PAs to train locally in emergency departments, the health system would benefit. Research shows that by including PAs as part of a collaborative health care team, effectiveness has improved and higher levels of service to patients are delivered. It would also allow other health care providers the chance to be introduced to the PAs and allow for better integration when approval from the government comes.

Before I hand it over to Erin, I spoke to Colonel Jonasson and he is heading up a program for military PAs working at the multi-service centre in Cobequid. Their last meeting was May 20th. That is progressing, but slowly.

On that note, I'm going to hand it over to Erin.

ERIN SEPHTON: My name is Erin Sephton and in addition to my role as the Alternate Director in Nova Scotia for CAPA, I work as one of three civilian PAs in the Nova Scotia pilot project in orthopaedic surgery here at the QEII Hospital in Halifax.

I graduated from the McMaster University PA program in 2013 with hopes of coming home to Nova Scotia. I worked in Ontario since then in family medicine and emergency medicine until 2020, when Nova Scotia Health Authority announced, with the support of the College of Physicians and Surgeons of Nova Scotia, a three-year pilot project in orthopaedic surgery with the view of permanently integrating PAs within Nova Scotia's health care system in establishing regulatory oversight. I was one of the three PAs hired to the orthopaedic surgery team and began working in 2020.

Since its inception, the pilot has been successful in integrating the three PAs into orthopaedic surgery in subspecialties including arthroplasty, trauma and bone tumour services. Despite the setbacks due to COVID-19, we have persevered and have been very successful in showing our impacts in patient care in the following areas.

In the in-patient setting, we're responsible for rounding and discharging surgical in-patients with overseeing care for approximately six to 10 patients per service daily. We provide coverage on both teaching and non-teaching teams, which allows for improved continuity of patient care and communication within the surgical team.

In the outpatient clinic setting, we assess and provide dictations for 45 to 60 per cent of patients seen in clinic with a volume that is capped at 40 outpatients daily due to COVID-19. Once COVID-19 restrictions are lifted, we will increase the volume of patients seen in clinic and improve the efficiency of assessing new patient consults and reducing the wait times.

In the operating room setting, surgeons are limited to only having one GP first-assist and will often require more assists in the OR due to the complexity of surgical patients. This includes factors such as rising BMIs greater than 40, revision arthroplasty cases, unstable or medically complex tumour cases and polytrauma. Not all surgeons have residents or learners, so having a PA allows them the support to proceed with these complex surgical cases, as well as ward management.

We have also begun some PA-led research, which, pending approval from the ethics committee, we are in the midst of showing surgeon satisfaction with the care provided by PAs, as well as improved efficiency in surgical care. Based on the multiple surgeons who have been inquiring about hiring more PAs, we are confident that this research will show and prove that PAs are safe and efficient medical practitioners.

[2:15 p.m.]

With the successful integration of PAs in surgical settings, we know that PAs have been instrumental in the improvement of patient care and other settings. PAs can help reduce wait times in primary care, which allows for more same-day appointments to be offered. PAs also help reduce wait times in the emergency departments, where key benchmarks are brought down, such as reducing the number of patients who leave without being seen and reducing initial patient assessment times.

PAs can also improve care in rural and remote communities, increase access to mental health services, and improve care for seniors in long-term care. In Canada, PAs are alleviating the health care systems, including provinces such as Alberta, Manitoba, Ontario, New Brunswick, and as Peter mentioned, the Canadian Armed Forces. PAs are changing the face of health care in these jurisdictions.

PAs have also been readily available for redeployment during the pandemic in the jurisdictions where they can. Our ability to adapt and be flexible has allowed some PAs to be redeployed to help on the front lines of COVID-19 and some have even shifted to virtual care so they can continue upholding excellent care for patients.

I would like to echo Peter's remarks that by taking steps to implement the PA model here in Nova Scotia, there can be significant impacts on health outcomes, access to care, and to costs. Further to this, there are many experienced PAs who have left Atlantic Canada to train and practise medicine elsewhere. I am confident that they would jump at the opportunity to return home, as I did, and that their skills would offer an immediate boost to capacity in the province.

THE CHAIR: Thank you for your opening remarks. We can start now with the questioning and we'll do a rotation. We will start with 20-minute rotations, starting with the PC caucus, followed by the NDP, and then the Liberal caucus. We are ready to go with the PC caucus. Ms. Adams, you can start your 20 minutes at 2:16 p.m.

BARBARA ADAMS: I am very happy to have all of you here. As we all know, health care is about 45 per cent of the provincial budget and physician expenses are about 20 per cent of that, so we're always looking for ways to improve things.

I'm a physiotherapist by trade for 40 years, so I'm really familiar with orthopaedic wait times. I'm wondering, since the pilot started, if you have a sense of whether the wait times have gone down since the pilot study started because, according to my records, the wait times especially over the past year for knee surgeries - not the consult time itself - has risen from 510 days to 660 days. Hip replacement wait time for the actual surgery rose from 420 to 580.

I'm just wondering if you believe that your program has directly impacted those wait times. I don't know if Erin perhaps would like to comment on that.

ERIN SEPHTON: Unfortunately, with COVID-19, we had reduced some of the wait times for surgery, but again, with the third wave, the wait times did increase again. This is an interesting question because in Nova Scotia, we have limitations on how many surgical patients we can put through a year. I believe with the upgrades in Dartmouth General Hospital, we do believe there will be more arthroplasty cases to go forward, but unfortunately, this hasn't happened yet.

I do feel that the efficiency of care for surgical patients between cases has definitely improved. This should reduce wait times between OR cases, but again, we do have some limitations. In other provinces, they can actually have multiple rooms for PAs and surgeons to work out of, but unfortunately, we do not have that option here in Nova Scotia at the moment.

BARBARA ADAMS: I know that with the opening of the Dartmouth General, we're going to be losing the VG Hospital, so we gained some beds, we're losing some beds. We're not really that far ahead. One of the proposals from the PC Party of Nova Scotia was to open up the OR times in Nova Scotia because we kept hearing from surgeons that they would operate far more often than they are doing right now, but they can't get OR time. In fact, I know one orthopaedic surgeon who is a relative by marriage. She and her father are both orthopaedic surgeons and when someone complained to them about the wait times, they said to write your MLA.

I'm just wondering if that's what you are hearing as well - that surgeons would appreciate having more OR time - and what your thoughts are on that.

ERIN SEPHTON: I absolutely agree. Surgeons love to operate. We do love having a full scope of patient care and providing good follow-ups and that sort of thing, but absolutely, surgeons would like to be operating more, and seeing especially our arthroplasty cases increase over the years.

Again, with some of the issues that there are, being limited GP first assists or even - we've just introduced nursing first assists as well. They're still quite limited, so having PAs - but again, allow for that continuity with the surgeons to be able to produce more surgeries safely.

BARBARA ADAMS: I'm just wondering if you could comment for me briefly: What is the training level? For physical therapy, I know it's a master's degree, which is what I took in school. How long is the training for a physician assistant?

ERIN SEPHTON: Currently in Canada, there are two approaches to PA training. There is a requirement of at least three years of an undergraduate degree, and then it's an additional two-year condensed program for McMaster and University of Toronto. Having said that, it is a two-year program because the McMaster medicine program, which this is mirrored from, is only three years, and the University of Toronto program - they require hands-on training, so many clinical hours. At the University of Manitoba, it's a master's degree, so two years as well.

BARBARA ADAMS: That's great. I know with clinical nurse practitioners, we changed the legislation here so that they can operate independently of a physician, so that is helping to reduce the wait time, but we still have 66,000 or more without a family doctor. Our PC Party has offered to give every single one of them right now a telemedicine physician subscription. I'd heard about that. The military in Halifax, because I have CFB Shearwater here, so when family members get posted here, the military member gets a doctor, but the family doesn't. CFB Halifax had done a trial where they gave 100 family members a telemedicine subscription, and we've offered to do that.

What would your role be for those Nova Scotians without a family doctor right now in Nova Scotia?

ERIN SEPHTON: Having worked in family medicine and emergency for the past seven years, basically what we allowed is almost double the volume of patients that are to be seen while providing support and having support of a supervising physician. I know first-hand that we increased our roster - we doubled our roster sizes from just under 1,000 to over 2,000 per supervising physician that I worked with, so this would allow more patients access to care.

We do work semi-autonomously, meaning that we have to be under a physician and their licence, and with the appropriate training we can and do see patients completely independently, but there are some rules involved in terms of having established rapports, and someone has to be available on site. My hope would be that we would be able to easily integrate PAs into family medicine as well as emergency and other primary care sites, and just allow to see more patients.

BARBARA ADAMS: We're going to alternate questions, so I'm going to go to my counterpart right now.

THE CHAIR: Mr. Ryan.

MURRAY RYAN: Ms. Sephton, a couple of questions. I heard about the pilot program and being able to do consults faster, get patients in the door faster, but the first thing that came to my mind was kicking the can down the road, because there's still a shortage of OR times, so rather than people being in the queue of the wait-list to get their consult, now they've got their consult, but they're in the queue now for OR, so you're moving them around from one bucket to another, if you will.

I'm curious, just from listening to your chat at the beginning, do you find that the patients who are waiting for various orthopaedic procedures and that - that they're happy with getting the extra attention? Rather than just sitting there for eight, 12 months, 18 months, that the constant interaction and communication provided by the physician assistants is a value-add for them mentally?

ERIN SEPHTON: I absolutely agree with that. Not only are we able to reassess patients within that unfortunate wait time, it's also important to note we can provide other non-operative treatment options, so by allowing a PA to help the surgeon to reassess these patients waiting for surgery, we can offer things like non-steroidal anti-inflammatories, joint injections, or even expedite and move them up on the surgical case list depending on whether their condition changes.

This is definitely something they appreciate. They appreciate the face time, as well as just checking in and seeing if things have changed. Believe it or not, some people actually do get better on their own, and then they can defer their surgery until they feel it is needed. Yes, absolutely, it's helpful to patients as well.

MURRAY RYAN: You just answered my follow-up, which was going to be along the lines of having that added consult, that more frequent visits, what have you. Situations can change so rapidly, especially when it comes to health. What's not an issue today could be a five-alarm fire tomorrow. Conversely, it could go the other way: the patient could have some improvement. That's very good.

My next question would be to Mr. Thibeault, related to PAs. As I have read, they owe their history back to the military and medics from what I've seen. I'm curious, how many physician assistants are in the military currently?

PETER THIBEAULT: Currently, the last check before I retired from the military in November was around 120, but the Canadian Forces was trying to reduce that number a little bit, down to 109, because that's the way their model is. In Nova Scotia, there are 22 physician assistants working in the military just in the Halifax area. I know there should be

two in Greenwood. That's where they're at, 120, give or take.

MURRAY RYAN: Would the physician assistants be spread out across the various arms of the armed forces - i.e. Air Force, Army? M.A.S.H. comes to my mind, your medics. That's the thing that just jumps to my mind right off the top, and then maybe those will be the three arms, but how about the Coast Guard?

PETER THIBEAULT: There are physician assistants only working in the Canadian Forces. There are none on the Coast Guard ships. I actually was Air Force serving in the Navy. My career's kind of funny, because I've only actually - the uniform doesn't matter: Air Force, Army, or Navy, because medicine is medicine. I wore an Air Force uniform, and I only actually spent six months with the Air Force. The rest of my time was with the Army, and the majority in the Navy. The Coast Guard does not have any physician assistants.

MURRAY RYAN: I'm going to hand it back off to my colleague, Ms. Adams.

BARBARA ADAMS: Dr. Grant, I'm wondering what the College's position is on this. I know that 40 years ago when I started, there weren't so many allied health professional scopes of practice. I'm just wondering what the College's position is on physician assistants in Nova Scotia.

DR. D.A. (GUS) GRANT: I thought I was going to have an opportunity for opening remarks, so I'll summarize what I was going to say. The College is a creature of statute. The Medical Act creates us, gives us our authority and our jurisdiction. The Medical Act is silent on physician assistants, so it would be easy for me to say that the College has no position about physician assistants, but that would be disingenuous. There is a section in the Medical Act that gives the College the authority to permit others to engage in designated aspects of the practice of medicine. So there's a wiggle room clause, and we use that.

I think it's fair to say that the College supports and recognizes that there may be a role for physician assistants in the provision of Nova Scotian health care as physician extenders. I think we've demonstrated that support. Both the previous witnesses have outlined projects in which the College has supported physician assistants like the orthopaedic project, which is ongoing. It's unfortunate that COVID sort of interrupted this year's first measurement of the success of that project.

Mr. Thibeault made reference to a program whereby we're just putting the final touches on approving the placement of presently uniformed physician assistants into Nova Scotian emergency rooms so they can both provide service and keep their competencies current as they wait to be deployed.

The College sees a role, but I'm a regulator and the Medical Act says that my job is to serve the public interest through the regulation of medicine - so for seeking to explore

roles for physician assistants, we need to explore roles where there is adequate regulation. How do we oversee this? How can the public be assured mechanisms for accountability? Stuff like that.

[2:30 p.m.]

The national landscape is mixed. There are three provinces that regulate medicine: Alberta, New Brunswick, and Manitoba. Ontario sort of does, but it's through a different mechanism. When we look at these projects, our challenge is not whether physician assistants might help, but how might they help safely and how might the public be able to have a degree of accountability?

What's the College's position? We see these folks as having valuable and good training. If we're going to explore their role in Nova Scotian health care, the College would be interested in ensuring that they're providing these services in a way that can be regulated so that we can be assured that they're safe.

THE CHAIR: Thank you, Dr. Grant. I do apologize. You were supposed to give remarks and I didn't see that in my notes. Thank you for giving them now and I apologize.

D.A. (GUS) GRANT: I can give more, if you wish, but I'll be happy to defer to questions.

THE CHAIR: I'm sure you'll get a chance from all the other MLAs to be asked those questions. Ms. Adams, go ahead, please.

BARBARA ADAMS: Since we didn't get your remarks up front, it would be wonderful if you could submit them to us because I would like to read them. As a researcher, I'm always challenging my own profession to have evidence that what we do makes a difference. I think specifically of orthopaedic surgeries. I know that there are physiotherapists who work in the emergency rooms and with orthopaedic surgeons as well.

Where you have an option of clinical nurse practitioners, physician assistants, physiotherapists, do you feel that there is enough research that each of those individual professions has done to say, we are the most cost-effective, useful service - we can either help with wait times, improve outcomes? I personally think there's not enough for any of our professions to substantiate some of what we do, but I'm just wondering where we now have clinical nurse practitioners versus physician assistants, how do you make the determination when you are deciding which role to fund for what? Does the College have enough information to do that?

D.A. (GUS) GRANT: The College is a regulator. We're not a funding organization. As a regulator, I like to stick in the regulatory swim lane. However, when Orthopaedics came to us with the proposal to pilot this, we wanted to make sure that we - when you have

a pilot project, it implies that there's a beginning, middle and an end, and there's a demand that the effectiveness of the program be measurable.

When the program was put together, our approval was hinged on reporting as to outcomes, but you have to be careful as to what you're seeking to measure. I think it's only fair to recognize - hey, folks, there has been a bug that's gone around the world in the last year and a half and there has been a hand grenade thrown into many things right now. I'll be curious to see how the pilot project can report on the last year.

Measurables are important. An underlying point to your question, I think, was: How do we distinguish the independent contributions of a physician assistant in and of themselves as compared to a nurse practitioner, an intern, a resident or any other number of physician expanders? Clinical assistant is another example. I'm waiting to see that data, but I perked up when you said that there's evidence that nurse practitioners have shortened wait times, because I'd love to see that evidence too, because that's the type of thing we like to follow.

Again, my swim lane is regulatory. When we approved the pilot project, it was with specific parameters or reporting requirements for performance. We are not in the business of determining who should get which funds from the government.

BARBARA ADAMS: I'll just say this: It was actually physiotherapists who had shortened wait times. I don't have that information on clinical nurse practitioners, and I appreciate it's been a lousy couple of years to do any kind of research because nothing can be quantified.

I am excited about the potential for the physician assistant program because with so many thousands of people without a family doctor, anything that we can do to facilitate a physician's role and work in partnership, I think, is a great thing. I'm eager to hear more through the rest of this session.

THE CHAIR: The time has elapsed for the PC caucus. We move on to the NDP. Ms. Chender, go ahead.

CLAUDIA CHENDER: I think I'll pick up on this thread for a minute. We're lucky to have a regulator who is a physician and a lawyer, so I'm going to pick up on Dr. Grant a little bit - what you were saying about the Medical Act, which is helpful in understanding the context here. You do mention that there are two other provinces that are regulating through the College and one in some other similar way.

Assuming that the pilot project is going to be successful and we have the data to measure that, what would a regulatory system look like? Would you anticipate changing that Act to specifically name this role and outline more to do with it? What would you be looking for and what would you need? As a regulator, you can just regulate, but what else

do you need? Do you need a legislative amendment? I'd be interested in hearing what a good regulatory system would look like and what it would take to stand it up.

D.A. (GUS) GRANT: I hope you can appreciate that I don't have a fully prepared answer to that. I think it would be inappropriate to simply expand the penetration of physician assistants relying solely on this discretionary clause in the Medical Act. In all likelihood, there would need to be attention focused on either our Act or regulations. I suspect it could be done through the regulations, but I'd rather give you a more considered response than that.

Again, I'm going to repeat: To me, this should not be a question of whether physician assistants can provide valuable service. They are well-trained folks and our military relies on them, and that's a high-standard organization. But I'd like to make the point that if they're going to be acting autonomously but not independently - which is what they do - they need to be regulated. The member of the public who sees a physician assistant in isolation needs to know that there's oversight and needs to know that there are mechanisms of accountability. I bring the bias of believing that regulation protects people. Otherwise, I couldn't sleep at night.

I think there would need to be a legislative framework. I see Gordon Hebb is on the call and he'd probably be in a better position to tell me what's needed, but my sense is it might be able to be achieved through regulations. It would best be achieved through changes to the Medical Act.

I think it was MLA Adams who said the data is very difficult to read through as to which of these physician extenders are cost-efficient. Many people would jump to the conclusion that it's as plain as the nose on your face that this will make things more efficient. I don't know that I know that. That's why we're proceeding as cautiously as we are.

These people are well-trained and can offer a service. I think they need to offer a service within a program that has oversight and regulation. There are other jurisdictions that have enjoyed it. There's not much penetration of it in Canada, apart from the military.

THE CHAIR: I saw that Ms. Sephton would like to add a comment as well. Go ahead, Ms. Sephton.

ERIN SEPHTON: I just wanted to add that as of two weeks ago, the Ontario Government and the CPSO will be regulating the Ontario physician assistants as well, so all provinces will be regulated.

THE CHAIR: Back to you, Ms. Chender.

CLAUDIA CHENDER: I appreciate that answer. I think before I switch gears a

little bit, just to be clear - I guess this is a question either for Dr. Grant or anyone else who wants to weigh in. Two questions. One is: Would we anticipate that the College would take on that regulatory role? A lot of other health professionals have their own self-governing bodies so is that an open question? As we do this pilot, are we thinking that it would fall into the basket of the College of Physicians and Surgeons?

I guess the companion question to that is: Does the military regulate, centrally, physician assistants and what does that look like? Maybe first to Dr. Grant and then to either Ms. Sephton or Mr. Thibeault.

D.A. (GUS) GRANT: The military operates within its own jurisdiction - the federal jurisdiction - so when physician assistants are working for the military, they are working within a federal jurisdiction and subject to what is, for all intents and purposes, the regulation of the Canadian Armed Forces.

Your question seemed to imply a desire to make my job more complicated. I don't particularly appreciate that. I think the national movement is clear and that's towards fewer and fewer regulatory colleges with the same. I think there's an appetite in Nova Scotia - I can certainly say there's an appetite within my board and I think I can speak on behalf of other regulatory colleges - to see amalgamations of disciplines within adjacent fields.

Right now, it comes to the College insofar as we're exercising this discretionary authority. If there is a better college to provide shelter, if you will, to the physician assistants, great. I think if I was asked the broad question as to whether it would be appropriate to introduce what would be the 26th or 27th health regulatory college in Nova Scotia, I would say, well, we're a pretty small place - I think we can do it. We might wish to consider less, and more consistent, regulation through less regulatory colleges.

CLAUDIA CHENDER: I appreciate that answer. I think that is important context as we think about moving forward. Of course, we hear a lot about cutting red tape in the business context, but we don't hear a lot about it in other regulatory context or non-profit context, and it feels like that's what maybe you're pointing towards a little bit, Dr. Grant - that we can streamline things a bit. That's very helpful.

I guess I want to ask, maybe turning a little bit - I know in the opening comments, there were some comments about the roles of physician assistants and some of the successes, and acknowledging Dr. Grant's comment that it has been a very unusual 16 months or so, to say the least. Given that, I wonder - and I apologize if this is available information that I haven't seen - we have a pilot, we have measurables in the pilot. Is there any sense of what some of those benchmarks were - where we are specifically in meeting them, specific outcomes? I'd love to hear more information on that from either Ms. Sephton or Mr. Thibeault or Dr. Grant.

PETER THIBEAULT: Erin would probably be able to answer on orthopaedics, and

that's great, but I just want everybody to be aware that PAs don't just specifically go to orthopaedics. My classmates, two of them work as neuro physician assistants in Edmonton. I have many friends all over, family practices in Ontario, plastic surgery in Manitoba, orthopaedics in lots of places, neurology - all parts of medicine PAs work. As for the pilot project, yes, I think Erin would be better suited to answer that question.

[2:45 p.m.]

ERIN SEPHTON: When it was communicated to me and the other three PAs who were hired, it was not so much driven based on numbers, because again, we are limited in our capacity for operations, but it was to improve the efficiencies - for instance, the efficiencies of my surgeons. I work with the Dartmouth General Hospital surgeons to operate in Halifax, so it basically allows them, while I'm caring for patients on the ward - they're able to go ahead and work in Dartmouth General and see patients, and we communicate very effectively, so I know in terms of efficiencies, the next PA-led research that I am planning is to show the time savings at least, and then, as well, other studies have shown the improved efficiencies as well as cost efficiencies, in terms of not having to hire GP assists and other members.

I appreciate Dr. Grant's input as well, because it was my understanding that the measurables would be the efficiency, the time, and patient satisfaction, reduction of patients returning to the emergency post-operatively with complications, and that sort of thing.

D.A. (GUS) GRANT: I hope this doesn't sound flippant. We have to be able to do both addition and subtraction. One of the things that I hope would be considered in the determination of whether the pilot is a success is a simple proof of concept notion. This pilot has essentially a constitution, if you will. It defines the scope of practice for the work being done. It defines the level of oversight that we're looking for. It defines even the continuing professional development that we expect PAs to be able to participate in.

You have to realize that specialist doctors working in an academic setting can sometimes get overwhelmed by management if you've got a fellow, two residents, a medical student, an intern, a nurse practitioner, and then various other ancillary health professionals working on your team. It's hard to effectively fold in another physician expander, however well-trained he or she might be.

Whatever the deliverables are, they're going to be so confounded by COVID, you're not going to really be able to do thumbs up, thumbs down as to whether there were newfound efficiencies, but we may be able to learn if this is possible. We may be able to learn what the right clinical setting for this is, and as well, I hope there will be experience delivered to the physicians in the orthopaedic program, because management of a new cohort of expanders takes time. Too often, these things get quickly hurried along, and it's being managed off the corner of someone's desk. That's not what's being done here, and I

think there will be important learnings from that too, irrespective of the COVID hand grenade.

CLAUDIA CHENDER: That's helpful. I'm still curious, what are the specific deliverables for that pilot? Ms. Sephton, you mentioned the research that you're trying to show, and Dr. Grant, you sort of said hopefully, we can add and subtract and figure it out. Is there a document? Is there somewhere that says we're starting this pilot and this is how we're going to measure efficiency and this is when we're going to measure efficiency? If so, is that in the Nova Scotia Health Authority? Do we not have someone to ask that or does the College hold that?

D.A. (GUS) GRANT: Yes, I'm sure. I'm running through the internal Rolodex as to where that might reside right now. I'm certain probably the most definitive document sits with Ortho. I believe it was initially penned by - I can't remember the PhD's name - Marcy Saxe-Braithwaite. Is that right, Erin? The College saw various iterations of it as orthopaedics sought our approval of it.

I suspect we have a final copy of it, but I'm certain orthopaedics does, so that would probably be the better. Orthopaedics subsequently went to the Province for funding, I would assume, so that's probably where it landed. That's just my best guess. If you come up dry, please reach out and I'll see what I can find.

ERIN SEPHTON: I do believe my supervisor has that document. We can hopefully share that with you as well.

CLAUDIA CHENDER: Thanks, that's super helpful. I think, Ms. Sephton, if you are able to get your hands on that and share that with the Committee, I think it would be great for us to see.

There have been a few comments that this has been confined - I know Mr. Thibeault, you mentioned it earlier - to an orthopaedic context, but of course, there are a lot of other contexts where we see the work of physician assistants. I actually wanted to ask about family medicine, which I know is something, Dr. Grant, you might be familiar with in your former life.

I know for myself, currently I have about a six-week wait to see my family doctor. Partly that's COVID-19, but partly that's just the way that practice is structured. I think that may have to do with a lot of things. I think it was great to have that financial incentive for doctors to take more patients, but also it means doctors have massive caseloads of patients and only so many hours in the day, and of course, we continue to have a shortage of physicians. That's just a real situation that we're dealing with.

I guess I'm curious - and again, any of the presenters can answer this, but it sounds like Dr. Grant maybe wants to start - the role that physician assistants could play in primary

care and in helping to just get some primary care for all the Nova Scotians who don't have it and get better access for the Nova Scotians who do on paper, but not really be able to access it in the way they need.

D.A. (GUS) GRANT: On this, I'm truly neutral. The College certainly recognizes that there is a role that physician assistants are trained in such a way to add to primary care. Again, I revert back to my bias. It makes it sound like it's a nasty word to my position - the College's position - which is we need adequate regulation.

Adequate regulation and oversight is easier to achieve within a structured program such as orthopaedics or neurology or a stroke service - which I suspect Peter may have been making reference to - than it is in family medicine. I'm not saying it's not possible, but if the College were to be the regulator of physician assistants and physician assistants were to penetrate into primary care and family practice, we'd have to look very hard at how to provide the appropriate oversight and regulation. It's much easier done within the confines of a big department in a hospital.

ERIN SEPHTON: Thank you very much. I get very excited as I spent my first seven years in family practice. This is something that is very near and dear to my heart. I started off as a paramedic here down on the South Shore and saw the poor access to emergency departments as well as family medicine. From my experience, quite a few - I wish I had that number for you, but a lot of physician assistants in Ontario are in primary care and family medicine.

There are different models, of course, of how they work. I was in a family health organization so as a rostering base system and having worked there for seven years, I had three supervising physicians. We had roster sizes between 1,800 and 2,400 patients. Our wait-to-be-seen time was within a week. If it was urgent, it was always a same-day appointment, so we had very low times to be seen. Again, too, it's very nice because my physician and I would work together. We'd have two different schedules but kind of flip between the two to allow for more streamlined service.

If there was a patient who had some more urgent issues or mental health that we needed to address, we could spend the time. You could spend half an hour seeing that patient, and it would not interrupt the flow at all. It's wonderful to have PAs in primary care, and this is something I'm quite interested in as well and learning more about the model here in Nova Scotia, because essentially there was direct supervision, as I worked directly alongside my physician. For quick-and-easy, bread-and-butter things, they wouldn't always see the patient, but there was always an established rapport and there was always consent from the patient that they knew that they were getting the care from me.

THE CHAIR: The time is exactly 2:56 p.m. The time has elapsed for the NDP caucus, and now we move on to the Liberal caucus, starting with Mr. Porter, I believe.

HON. CHUCK PORTER: Thanks to our witnesses joining us today. This is a very interesting topic, one that I'm quite familiar with. I spent 17 years in this province as a paramedic. I've done my share of calls picking up military folk, going to Stadacona. Understanding the process well, having a number of family members also in the military.

This has been an interesting piece. This is not a new topic. This is the interesting part about today. This is not a new discussion. I remember meeting with folks from PAs some years ago and trying to get inroads into how we practise and offer more to Nova Scotia. I know there's this whole regulatory piece, and Dr. Grant, I appreciate that very much. You have to have some guidelines, you have to have that oversight. It is important. As a paramedic, I worked through that process, as we evolved through EHS, which you would be very familiar with, I'm sure. We went from where we were to where we are. That didn't happen overnight, I appreciate that, but it did happen.

There is room. We have very qualified individuals out there in the streets doing primary care. I believe physician assistants do have a role to play in this province and could offer us a great deal, quite frankly. It's a shame that we haven't gotten there yet. I look forward to a day when we are not only taking advantage of those physician assistants, but we also have infrastructure. Look at the Stadacona Medical Center, for example. Peter or Erin or somebody could answer the question probably: How many patients would be in that facility at any given time? Mass casualty incidents, other things that happen, ERs overbooked.

There are all kinds of opportunity here for health care to further advance in the province of Nova Scotia using one of our biggest resources, which is the military in this province that we are known for - certainly in and around our biggest, in our capital of the Halifax Regional Municipality. I would be interested to hear what your thoughts are on that, and any of you can answer that. I do understand the regulatory part, although some days I like to say that Nova Scotia is overregulated. My predecessor, Ron Russell, talked about way back in his day, Nova Scotia had so many regulations, sometimes we struggle to figure out where we need to be.

We're talking public safety, though. Regulations and oversight are extremely important. It has to be there, but I don't think it's something that blocks us. I think it's something that advances us. I know everybody's busy. Dr. Grant, you talked about how you have a fellow, you have residents, you have this, you have that. How many more can you add to the team? We have seen in Nova Scotia in recent years the clinic model, family practice, walk-ins, et cetera, which have worked extremely well, which have taken patients out of the ER. There is an opportunity here, in my personal opinion, to get these folks working as part of health care in Nova Scotia.

This is a topic that I'm very passionate about and I'm very interested in your thoughts on what I've said so far.

[3:00 p.m.]

THE CHAIR: Mr. Porter, is that for Dr. Grant or for Mr. Thibeault?

CHUCK PORTER: It doesn't matter. I'll look for a comment from Dr. Grant as well as maybe Peter and/or Erin.

THE CHAIR: I'll start with Mr. Thibeault and then move to Dr. Grant, because he put his hand up first. Go ahead, Mr. Thibeault.

PETER THIBEAULT: The physician assistants work - the military ones work directly under a doctor, a supervising physician. As you know, the Navy ships go out, and there is no doctor right at hand. He's not there, but he's reachable via phone call, like Diane working right now in northern Ontario. My supervisor is in Timmins, Ontario, and I can reach him just by picking up the phone. We do work 24 hours. There are two of us - I'm the night shift guy and my other partner is the day shift guy for this rotation. There are only two of us up here. Then we have the Emergency Response Team (ERT) paramedics.

What I'm getting at is that I understand the regulation. Ontario just had their third reading of their bill. I don't understand the politics of it all, but after a third reading of a bill, it's pretty much passed, so I would think that Ontario is now a regulated province for PAs. That's up to you guys to figure all that out, but that's good for them.

New Brunswick has it with regulation. It works. I agree, we need regulation. PAs though, we work all over the place and we can assist in every aspect that you're talking about - family care and walk-in. Doctors are very busy. They don't need to see a person who has a common cold right away. A PA can take care of it. If it's something worse or a case is seen and there's like - well, I'm going to move you up, well, then this is where the physician assistant can really help speed up wait times. This is why I think Nova Scotia definitely needs PAs, because of the wait times and stuff like that.

Just so everybody understands, a physician assistant does not need to have a supervising physician right beside him physically. They only have to be a phone call away.

D.A. (GUS) GRANT: Listen, there's a wonderful enthusiasm and momentum being voiced by all on this call, and I don't want to dampen that. I think there's a role for physician assistants to play. I think there's probably a role for physician assistants to play in any number of disciplines, but structure has to be imposed. By the way, access to care is not a problem unique to Nova Scotia. Please don't jump to the easy conclusion that if we did this, we'll solve all these problems.

New Brunswick has two or three physician assistants working there in a very defined role. I hope this group will hear from me that if you turn to my College for the regulation of physician assistants, we'd be happy to take it on. You just heard in Peter's

example - if you were listening closely, you would have heard a number of nuanced problems. No, a physician doesn't need to see the common cold, but what one does the physician need to see? You need to have a scope of practice document. That's going to vary from discipline to discipline. You can see this, but the doctor needs to see that.

Then the real beauty, the secret sauce that makes physician assistants truly effective, is that their relationship evolves with the physician for whom they work. It builds over time, much like - and I hope this isn't felt to be in any way diminishing, but my executive assistant does a completely different job than she did a number of years ago as my work has evolved and her work has evolved. So there's an evolution to it.

My point is that oversight, scope of practice, accountability is required. Catastrophize for a moment. You go to the emergency room. You're seen only by a physician assistant and some disaster ensues. The public will have an appetite and have a right to both accountability and remedy, and we need to have those mechanisms in place.

There's a role to play. There's not a big number - there is a potential supply, there's probably an appetite. Ms. Chender talked about diligence. Yes, it's going to take diligence to put these programs together. Hopefully not undue diligence - I like my porridge just right. There is work to be done for this. It's not simply, let's open up all departments to it.

THE CHAIR: I believe Ms. Sephton had something to add.

ERIN SEPHTON: Yes. Not to spring this on you, Dr. Grant, but I and the other PAs are working on a proposal for regulation as well. It's, of course, in its infancy. I've just had our medical directors offer policies in creating that structure of framework within Nova Scotia Health Authority that's in its last stages. This is something we're absolutely aware of and we want to practise responsibly and safely for the Nova Scotia public, so this is something we will be doing.

CHUCK PORTER: I appreciate your comments. I want to follow up on Dr. Grant. Sick people in Nova Scotia get looked after right away. Somebody comes in with a heart attack, emerg, queue, traumas - these people are looked after. There should be no misconception out there. Nova Scotians who are sick - and when I say sick, I don't mean with a cold - and in need of emergency care are getting looked after. We have a fabulous system in this province. There is a wait-list for some things. I get that, I appreciate that very much. I know a lot of people who are on lists for surgeries and so on. I've always said that.

Dr. Grant, you touched on scope of practice - that is exactly correct. There has to be a scope of practice put in place. It can work very well, I think. Again, I'll refer back to the paramedics - "doc in a box," we referred to them as - somebody on the phone. Now there's somebody getting lined up to be in the centre, offering that advice when you're not sure. There is a lot of ability here.

It will be very interesting to see where this goes. I hope there is success with this program. Training, recognizing sick is an important thing when you're working in the field. There's no question about that. What kinds of things are going to work in the field? Are we going to work in clinic models where you can have that oversight and you can work within your scope? Maybe that's a starting place, I don't know, but I do hope this moves along and gets to the College and gets the conversation started.

I think it's an exciting time to be talking about it. I agree that the numbers probably aren't - I don't know how many in Nova Scotia would ever be able to take part in such a thing. I'm not a big fan of pilots, but this may be something that is specifically in need of a pilot.

I do hope that the follow-up from today is that there is some movement that we continue down a path that can be successful - to continue to bring in all of these health care individuals who are dedicated and want to be part of this system. I think the PAs want to be part of the system in Nova Scotia and right across the country.

I'll just close with this bit on what Mr. Thibeault was talking about by way of Ontario passing regulation legislation, whatever is required. One of the things that has always bothered me is that across this great country called Canada, we've got every province doing their own thing. As a paramedic, I'm not going to treat somebody differently who is sick on the street in B.C., Alberta, Ontario or Nova Scotia. I'm going to treat them the same. Yet I've got to jump through a bunch of hoops to be registered in those provinces. It's just not a consistent application on many fronts - doctors, whatever it might be.

This is a national-based thing. If there is something that works - this should maybe be for Dr. Grant as the regulator - have discussions with partners across the country to say, how do we make this a national registry or program. Maybe they operate in Nova Scotia. It's all part of the oversight. I don't know.

This is not rocket science, in my opinion. Again, I'm not a doctor. I'm just an old paramedic. I appreciate the legal part of it, the regulatory part of it, and the medical part of it. I'll leave it at that. I see Dr. Grant raising his hand, so I'll let him go.

D.A. (GUS) GRANT: We'd prefer the "this is not brain surgery" reference, Mr. Porter, rather than "rocket science." [Laughter]

Medicine remains a matter of provincial jurisdiction and so unfortunately, that makes for a fabric of different approaches to licensure. I get frustrated by that observation, sir - though I respect you for making it. Licensure is incredibly consistent across the country. The physician licensed in any other province in the country can get a licence in Nova Scotia incredibly quickly. When they can't, there's usually a reason for that. I would encourage you not to simply assume that there should be - if you asked me personally, I'd

love there to be a national license, absolutely, and I'd love there to be absolutely consistent national standards. I've argued that in national meetings. When we put in place difficult licensure for certain physicians, you have to make sure the conditions, restrictions, and safeguards are transportable to other provinces.

Yes, I get your point, Mr. Porter, and quite frankly, I appreciate the point. There's always going to be a bit of a province-to-province variation. But the hassle factor, if you will, the administrative burden to move from province to province is vanishingly small. I can tell you, it's not a true barrier.

CHUCK PORTER: I know there are others who want to ask questions, so I'll move on.

THE CHAIR: Mr. Glavine, go ahead, please.

HON. LEO GLAVINE: I have had a little technical problem this afternoon, but I think we're doing okay.

I would like to ask perhaps Peter and Erin first a question around transitioning from their military careers into the hospital system, medical systems across the country, and of course Erin has the experience of moving into the orthopaedic team.

I know the military from being in a community here in Kingston-Greenwood, and talking to PAs, and actually have had a few more formal meetings in terms of their role here in our health system in Nova Scotia. I would just like you to speak, Peter and Erin, to the transition from the military into our health care system in the provinces.

THE CHAIR: I'm sorry, you'd like this to go to Ms. Sephton?

LEO GLAVINE: To Peter and Erin, because Erin's right here in the province.

THE CHAIR: Who would like to start first? Just a show of hands.

LEO GLAVINE: Peter, please.

THE CHAIR: Peter, go ahead.

PETER THIBEAULT: My transition was extremely quick. I was actually on a mission coming back from Europe, sailing across on HMCS Halifax, and I heard about a position opening in northern Ontario. I got an email, I replied, and the transition was just getting out of the military.

There are a lot of companies out there looking for PAs and they're taking them from the military. I know one just left two weeks ago, working in natural resources in the

Yukon. PAs are being lapped up by other resources because they can see the value that they offer to the people they serve.

For me, transitioning was very easy. I enjoyed my time in the military, my 32 years. I walked away with my head held high, very proud of what I accomplished, but it was time to move on and get back to practising medicine. It was seamless. My supervising physician is an awesome doctor who actually practised in Cape Breton, and now he lives in Timmons, Ontario. The transition for myself was very easy and seamless. It really was.

[3:15 p.m.]

ERIN SEPHTON: This might be a quick response. I'm not military-trained. I'm civilian-trained. I went through the McMaster program, so I can't comment on any military-based PA activities. I will say, having gone from a general practitioner to a more specified service as orthopaedic surgery, that again, with excellent training that these three university programs offer, there's a framework there to be able to transition quite flawlessly into other systems, as we're able to assess common complaints, make a differential diagnosis and form appropriate treatment and investigation plans. I can only comment that going between different subspecialties has its challenges adjusting to different practice styles, but otherwise it's quite easy.

LEO GLAVINE: Very quickly, Dr. Gus - you may have mentioned this earlier, but I was bumped off the call - what is your role now in relation to the PA pilot?

D.A. (GUS) GRANT: Not much in this respect. It's up and running right now. We expect to get regular reporting on the progress of it. Thus far, we've had positive assurances that it's going well, but I've not seen anything quantitative. I must say that it might have gone across my deputy's desk and I didn't see that.

The one thing I would add is: Peter, can you tell your doc in Timmins that there is a lot of opportunity in Cape Breton and I'm sure the good folks back home will welcome him with open arms?

THE CHAIR: The time has elapsed for the Liberal caucus. We'll move back to the PC caucus for 10 minutes. We're going to have another round of 10 minutes each, starting with the PC caucus and Ms. Adams.

BARBARA ADAMS: This next question is for Erin. When we looked at budgets, we know what the cost of a clinical nurse practitioner is and the supports that she or he offer. I don't know what the base salary is for a physician assistant. I know it might vary across provinces, but I'm just wondering: In Nova Scotia, what would the actual salary be?

ERIN SEPHTON: There are differences, depending on the subspecialty and how a PA is hired. There are multiple different funding models, especially in Ontario, but it is

similar to that of a clinical nurse practitioner. Novice PAs will start around $80,000 and upwards. Again, with a seasoned physician assistant, depending on the type of system they work in, they'll be similar to a nurse practitioner.

BARBARA ADAMS: Clinical nurse practitioners traditionally work 8:00 a.m. to 4:00 p.m. or 9:00 a.m. to 5:00 p.m. Some physicians have said to us, that's great for the daytime, but there's the evening and overnight hours, so I'm just wondering: Do physician assistants work 24 hours?

ERIN SEPHTON: We are able to work anytime, day or night. I think most prefer daytime hours, but it's whatever the coverage is. I know that for a lot of emergency departments, that time between midafternoon to early morning hours has always been a struggle to have adequate physician coverage, so we do see a lot of PAs working at the peak hours that are most necessary for patients to be seen.

BARBARA ADAMS: This question is for Mr. Thibeault. When I do a search on the cost-effectiveness of physician assistants, there isn't as much research as you would like to see there in terms of cost savings. One, of course - it's from Britain, so you can't really compare apples to oranges in terms of countries. I'm just wondering if you're aware of any research that shows the cost-effectiveness of physician assistants in Canada.

PETER THIBEAULT: No, I do not know of any cost-effective training. I just know that it's a valuable resource that everyone has tapped into and the other provinces have tapped into it and the natural resources have been utilized, and cost, I guess, was not considered. The value is more important.

ERIN SEPHTON: As part of my literature review, yes, there is evidence to show the cost-effectiveness. Specifically, I think Dunbar et al - Dr. Dunbar actually works with us as well. They did a study based on orthopaedic surgical services and cost-effectiveness in Manitoba. Again, there isn't as much PA-led research as compared to the U.S., but there are a few. If you'd like, I can send those to you.

BARBARA ADAMS: Just as you said that, I was just Googling it. One of the things that I know with research is that it's often a very narrow bar. One in particular with Dr. Dunbar: It's on a specific surgical procedure, so we have to be careful we don't translate and say, if you help with total knee joint replacement pre- and post-op, that that means we have a wide application. I know for my own profession, that's been a challenge for us over the last 50 to 80 years - is can you translate your effectiveness from one disease or condition or procedure into a full scope?

I will encourage you, as I'm encouraging all health professionals in general - we are at the point - it might not be rocket science or brain surgery. I'm a neuroscience physio myself. Being a health professional who's in the Legislature, it does come down to dollars and cents. We do have to require our researchers and health professionals to be able to

substantiate whether it's better to go with this profession or this - who the most effective is. I know it's a challenge to do that, but given that it's a $4.5-billion budget, I think we need to do that.

Although I know it's time-consuming and I know the pandemic is going to blow every research study out of the water that was going on, I'm wondering if you know of any other studies. Either Erin or Peter: Do you know of any other research studies - not a pilot study, which is necessary to see if a big study is warranted - going on in Canada looking at the cost-effectiveness of a physician assistant role?

PETER THIBEAULT: No, I do not. However, I can reach out to the organization or association and I can get back to you on that. That's a very good question. I'm sure the people in the administration would be able to answer that question for you.

ERIN SEPHTON: I agree with you completely, Ms. Adams. Yes, we do need this research, and this is something that Dr. Dunbar and myself are looking into for the second research product, so it's absolutely necessary.

BARBARA ADAMS: With the time I have left . . .

THE CHAIR: You have four minutes.

BARBARA ADAMS: Perfect. I know that you had mentioned something about how physician assistants can help in the emergency room, but I also know that one of the biggest holdups we have in emergency rooms is not being able to admit people because there are too many people in those acute care beds waiting to get into long-term care. Erin, I'm just wondering how you feel a physician assistant helps in the emergency department.

ERIN SEPHTON: That's a great question. I feel this stems back to primary care, and by having excellent primary care, we can avoid people having to go to the emergency departments in crisis or needing long-term care. In the emergency departments themselves, we do reduce wait times for definitely acute CTAS cases, three and lower. We reduce those times significantly.

In terms of our admission rates, I feel that when you have PAs and allied health workers who work efficiently together on the floor to have effective discharges, that this allows for better flow within the entire hospital. Again, I might clarify this. In the emergency department, we definitely help with the benchmark times of reducing your initial physician assessment time, as well as reducing those having left without being seen. Again, if you want me to specifically comment on long-term care admission rates, I can't quite on that one.

THE CHAIR: Dr. Grant.

D. A. (GUS) GRANT: We tend to fall into medical-speak and assume other people understand. What Erin was referring to was triage level - the less acute triage level.

Take specific examples: I'm not sure if Mr. Porter is still there, but in an emergency room, now the most common presentation in emergency rooms remains a sprained ankle. There are very established protocols as to when an ankle needs an X-ray and when it doesn't. Then there are very established protocols as to when it needs to be casted and when it doesn't. It would be extremely rare for a sprained ankle now to be seen by an emergency room physician, and it would usually be managed by a paramedic or a physician assistant. The same would be said of mechanical back pain, which I think is the second most common presentation to emergency rooms.

You can redirect stuff, but then again - and I'm sounding like a broken record - that requires scope of practice documents and clear delineation of who does what and when, and then clear reporting lines of - this isn't your typical sprained ankle, how do you press a button? There's structure, there are management systems and there are charters that need to be developed.

BARBARA ADAMS: I'm going to turn it over to Mr. Ryan.

MURRAY RYAN: I just have a quick question for Mr. Grant related to this whole pilot program. I can appreciate the challenges over the last year . . .

THE CHAIR: I apologize, Mr. Ryan, the time has elapsed. Next we have the NDP. Ms. Roberts, please go ahead.

LISA ROBERTS: Thank you for this interesting conversation. I want to just refer back to the comment from Mr. Porter that this discussion is not new. Yet we seem to have this very measured - and first, that I am aware of - pilot project of using physician assistants in Nova Scotia. Dr. Grant, you have referred a number of times to this coming forward from the orthopaedic group, which suggests to me that it was Orthopaedics that took the initiative, not the Department of Health and Wellness. I guess this appears to be in some ways a very modest first step, given that the conversation isn't new and given that emergency room closures have certainly been rising for a number of years now.

I wonder - maybe starting with Dr. Grant, Ms. Sephton or Mr. Thibeault - if you want to comment, I would welcome hearing from you: Can you comment on the pace and what is setting the pace for trying this and assessing it and figuring out if it's worth doing more?

D.A. (GUS) GRANT: There was a lot in that question, so I'll try to unpack it one at a time. I worry about your reference to keeping emergency rooms open. Physician assistants may work autonomously, but not independently. I'm not really sure that I would endorse the notion of an emergency room remaining open solely staffed by a physician

assistant. I'm really not sure. I'd have to look critically at whether an emergency room staffed only by a physician assistant could safely remain open if the physician assistant's only recourse was over the phone to another larger centre where an emergency room physician was present. I'm not saying I'm ruling that out. I'm just saying that took me a little aback.

Why are things moving slower than others might like? Well, because they always do. I think that the initiative that was brought forward by Orthopaedics took some time to develop. There is work that's needed to be done to pass muster, for instance. The division of Orthopaedics should be congratulated for having done the work and rolling up their sleeves with the College to put together a project that works.

[3:30 p.m.]

Orthopaedics was perhaps in the unique situation insofar as the work. Erin, I hope I'm not treading into your swim lane. The work of orthopaedics lends itself perfectly to a physician assistant role - I'm not saying other divisions don't, but orthopaedics works well. I think the orthopaedic pilot was built off a program where physician assistants were being used in McMaster or in Hamilton and one of the local orthos had experience there. There was work, there's experience, there was commitment to it.

I can tell you, the College would happily entertain proposals from other divisions if they were there, but people have got to do the work to do it safely and that takes time. Like I was saying to Ms. Chender, we've got to do addition and subtraction, and the docs and administrators were working really hard. They don't have space on their desks or time in their schedule to ask, how can we do this better? It takes time and work. People tend to underestimate the time and the resources required to build something and then to manage it once up and running.

LISA ROBERTS: I can't see Ms. Sephton, so if anybody else indicates that they want to comment on a question I ask, I'm glad for them to have the opportunity to do so.

PETER THIBEAULT: There is one thing about being a physician assistant - yes, we don't work independently, but we kind of do in a sense. Again, right now, I'm in northern Ontario by myself - well, I have my partner, the other physician assistant. But if you think about the Navy and go by those guys, there is no doctor out there. He is taking care of a common cold to a massive trauma. He is by himself, but we are never by ourselves. We have a paramedic. In an emergency room, there are nurses. There are other health care professionals who are there.

A physician assistant in an emergency room - I know that when I was doing my training in Dauphin, Manitoba, the student physician assistant was working in the ER and the physician was nearby, but he was taking care of everything. Anything that walked through the door, physician assistants - their scope of practice allows them to do all, run an

emergency. Advanced Cardiovascular Life Support (ACLS) - last rotation, we had a major trauma here in the mine site. It was me and my team. PAs are never really alone, but they are the pointy end of a stick, taking care of that trauma in those cases. Because of our scope of practice and our training, we can handle that.

For closing-down ERs, I think that a physician assistant can work there, and if there is an issue, you just pick up a phone and you can speak to your supervising physician who can assist there. I really do believe that physician assistants can help shorten or lessen closures of ERs.

THE CHAIR: Dr. Grant.

D.A. (GUS) GRANT: I think there are deep policy considerations to be chewed over on that. Nova Scotia has rural areas. Nova Scotia - with the possible exception of parts of Cape Breton - has no remote areas by traditional definitions used in medicine for rural versus remote. I know that it's a significant decision that will require policy consideration by all you folks as to whether it's better to keep a rural emergency room open staffed with a physician assistant connected by phone to another physician, or whether it's better to close those doors and redirect to a nearby, larger, more fully staffed emergency department.

I think Dr. David Petrie, the head of emergency services, is or at least was actively looking at that question as part of the pandemic response. I spoke to David early on in that process. All I'm saying is, that's a big decision that needs to be carefully considered.

THE CHAIR: You have one minute left. Ms. Roberts, would you like to say something? Would Ms. Sephton like to add something to that last one minute?

LISA ROBERTS: Maybe I can go ahead just quickly, if someone had an opportunity to comment. When I had a mishap and ended up at the emergency room, the person I saw was an advanced care paramedic, and maybe Dr. Grant could quickly comment on the different considerations of an advanced care paramedic versus the use of a physician assistant, or maybe somebody else would be more appropriate, but I was certainly struck at my experience and the fact that I did not see a doctor.

D.A. (GUS) GRANT: I don't know in a minute if I can clearly delineate the various roles, but I want to repeat, physician assistants have valuable training and are well-skilled to manage a lot of things that come into an emergency room or can be plugged into the machinery of the department and provide valuable, well-trained care. I hope you're okay, Ms. Roberts - it's increasingly the norm for conditions to be managed by ancillary health professionals like advanced care paramedics, and you can easily foresee a role of physician assistants. I'm just saying it takes work and structure to get there.

THE CHAIR: I know Ms. Sephton would like to, but time has elapsed. However, I

believe next is the Liberal caucus. Mr. Horne will be asking. Maybe he will let you finish your last comment. Mr. Horne, it's your turn. Are you okay with Ms. Sephton adding her comment?

BILL HORNE: Go ahead.

THE CHAIR: Erin Sephton, go ahead.

ERIN SEPHTON: Having been a paramedic - not an advanced care paramedic, I was a primary care paramedic, and the training is different in that a physician assistant is trained under the medical model, so our ability to recognize disease processes, pathophysiology, creating that differential, and really a much broader sense of things. Paramedics are very valuable. I think they are the staples in this province, and it's admirable how advanced that their scope has become. In terms of training, it is quite different.

BILL HORNE: A question for Ms. Sephton. I'd like for you to talk a little bit about your experience working in Ontario and how it compares with Nova Scotia, and if there are benefits for one province over another, or any experiences that would be beneficial.

ERIN SEPHTON: I'll admit my bias: I am very happy to be home. Ontario was wonderful for the past 10 years. I think what I have enjoyed about Nova Scotia - "enjoy" is an interesting word - it has taken a lot of work in terms of making the infrastructure within the hospital system to create this PA role, to form policies which we can work under, and then facilitate these medical directives. However, I think it's also a great experience in that we can create something quite special.

When I started working in Ontario, I was in the third class to graduate from McMaster, and at that time there was still a lot of red tape for us to work through. I was very fortunate. I had very positive, friendly physicians, so they allowed me to work to my full scope. I did create medical directives, was able to prescribe and do a lot of things autonomously. To their benefit as well, they could go on vacation. I would cover their practice with the support of one of my allied supervising physicians. We had a very nice system that way.

Nova Scotia is home, and the role, I will say, has been exceptionally well-received within the hospital. Everyone is just very excited to have PAs who are readily available, working in the operating room. The residents, the surgeons - they're not always available. Unfortunately, we only have coverage from two wonderful clinical associates. There's definitely lots of room for everyone, but I'm very happy to be home. I think this is a wonderful opportunity to create something quite special.

BILL HORNE: I also had a question - where's our . . .? My go again?

THE CHAIR: I'm so sorry. The wi-fi took me out and brought me back and nobody noticed at all. When it brings me back, the microphone is on mute and I didn't realize that, so I apologize.

BILL HORNE: Okay.

THE CHAIR: Go ahead, Mr. Horne.

BILL HORNE: Actually, I wonder for the military, Mr. Thibeault, about his interest and how quickly he switched over to becoming a PA. What about general PA people when they get ready to retire, which is generally 20 years maybe after service? There is still plenty of life left in the PA and I'm just wondering how easy it is for him or her to switch over to being a PA in this system - either by province or by country.

PETER THIBEAULT: Transitioning out of the military can be done in 30 days. Right now, most PAs are 25 years and after, they're considering retirement and stuff like that.

When I did my course in 2010, though, there was a mass exodus. My class was 30 PAs. We graduated with 26 PAs. By 2012, eight PAs had left the military - less than 20 years in, or give or take around 20 years - because Ontario was offering the positions and they jumped at it. They thanked the military for their service and the opportunities, but they wanted to practice medicine on the civilian world, so they went into Ontario and Manitoba. Those were the first two provinces that were having PAs back in 2010, 2012. Now, Alberta, New Brunswick, and hopefully in Nova Scotia, because we have the three that are working there.

The transition is not really hard. It's the opportunities. I hear from friends who have asked me when we will have PAs in Nova Scotia, because they want to come home. It's just waiting for the opportunity for them to come back and the positions to open up. I hope that answers your question.

BILL HORNE: Another question. I'm kind of jumping all over the place because many of these questions have already been answered. I'm trying to define a little bit more detail.

The universities in the Atlantic region that produce medical doctors - would they want to begin a PA program? You may not be able to until after your three-year pilot project has been assessed. Would that make sense, that the local Maritimes might try to set up that system at some universities?

ERIN SEPHTON: I might direct this back to Dr. Grant, but absolutely. My hope is that once we do establish the PA progression here, move ahead with regulation and the infrastructure that's needed, absolutely we need a program.

Currently in Ontario, they're only graduating - McMaster is 20 and then University of Toronto is around 18, University of Alberta is starting up, so we're only graduating maybe 70 PAs a year. Having said that, I have a lot of friends who would love to come to Nova Scotia and stay, so I think this would be a natural progression and an excellent next step.

BILL HORNE: I will support Dr. Grant. I think you do need all your i's dotted and t's crossed before you can come into a program like this - just from my life experience. It requires a lot of work - a lot more than probably all of us know here.

D.A. (GUS) GRANT: I wouldn't even know where to begin with the building of a curriculum and opening of a university department. I've participated in medical school curriculum and I've participated in reviews of faculties building largely from the ground up. I applaud your ambition and I applaud your love of place. I think it would take a lot of work to get a Dalhousie program in place.

[3:45 p.m.]

BILL HORNE: That ends my questions.

THE CHAIR: We have less than a minute left, and if I may say a couple of things myself. I'm not normally allowed to ask questions or comment because I'm the Chair, but I have a minute here. I had, as my colleague Ms. Roberts had, a broken arm, and went into emergency, and in and out. I honestly didn't know it was all paramedics. They've done an incredible job in Pod 5. I remember that. A few months later, my husband fell off a bicycle as well and we ended up in Pod 5, and I thanked them. It does work, and I have seen it with my own eyes, that they can do a lot of that work.

I also want to say, hopefully if it is available in other provinces, it will be wonderful to bring it here. I'm a medical interpreter, and I worked with NSCC to develop a curriculum, so if I can develop a curriculum, anybody can develop a curriculum. We can bring it here and we can - if there is a will, there is a way. That's all I would like to say on my behalf. I'm looking forward to hearing more and to graduate more students in that field in order to help our doctor shortage and our doctor issues in Nova Scotia.

Thank you all for being here, and I'm going to start with Dr. Grant for the final remarks, because I feel bad that I forgot him in the beginning.

D.A. (GUS) GRANT: Not at all. Ms. Adams had asked that I provide a copy of my opening statement, and I'm entirely confident these illegible hen-scratchings on the paper in front of me would be of no service to this committee.

THE CHAIR: Maybe you can use the time in your closing remarks to add a few

things that didn't come up.

D.A. (GUS) GRANT: Again, I would only say, please don't perceive the need for regulation as an obstacle to progress but rather as a necessary part of good and safe progress. Like I said, the College recognizes this training and sees a potential role for it, and if it's the wish of the Legislature that the College take it on, we'd certainly lean into it. These people take - like you and your husband, not all broken wrists are the same. People who work independently, or autonomously I should say, in taking care of patients need to be regulated, need to have oversight, need to have management structure in place, need to have defining scopes of practice, need to have continuing professional development.

This is not just a "let's open the doors." If we do wish to open the doors, there's work to be done, and I'm happy to participate in that work. I endorse the value of this breed of health professional, but there's work to do to get there. I appreciate being invited to this group.

THE CHAIR: You've been a great resource here today. Maybe Mr. Thibeault and Ms. Sephton, would you like to have some final remarks before we let you go and do our committee business? Would you like to say a few things, Mr. Thibeault?

PETER THIBEAULT: Thank you very much, everyone, for inviting me and Erin and, of course, Dr. Grant to this very important topic of moving physician assistants into the province of Nova Scotia. It's coming. I am fully confident that we will have physician assistants working here. The people are going to demand it soon. They're going to want better health care, and physician assistants are going to be able to fill that gap. Regulatory services, yes - Dr. Grant nailed it perfectly. You need that.

Ontario started with it before regulation, so like he said, don't let it be a stopgap, because they were working since 2010, and they just went into regulation. We know it can work. We have a scope of practice, we have to work under supervising physicians, but the health care and what physician assistants can provide is unmeasurable. I welcome the opportunity to - when my colleagues ask for a job in Nova Scotia and we can say we have positions available.

ERIN SEPHTON: Thank you all so much for this opportunity. Again, we're very excited to be the first three here for civilian practice and have the support of our wonderful military members. I'm hearing it again with efficiency. I would really like to stress that I understand and I practice by evidence-based medicine, and I would like research to prove to you all that PAs are effective and can help reduce costs. It'll just take me some time and non-COVID-19 numbers.

THE CHAIR: Thank you to all our witnesses today. It has been very informative and interesting. Hopefully, we'll hear more about this pilot and the success of it, with or without COVID-19. Thank you again for appearing. You may leave now so we can do

some committee business.

We are back to committee business. I see I have nothing on the sheet here. It says none. Is there any discussion?

The next meeting is Tuesday, September 21st, as we don't meet in July and August, from 2:00 p.m. until 4:00 p.m. The topic will be the Society of Atlantic Heroes. The witness will be Mr. Tim Brodie, the president of that society.

I see no other discussion. I will adjourn the meeting.

[3:52 p.m. The Committee adjourned.]