



The Health Profession Assistant: Consideration of the Physician Assistant Application for Regulation

August 2012 ▪ Volume 1



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August 31, 2012

The Honourable Deb Matthews
Minister of Health and Long-Term Care
10th Floor Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister,

We are pleased to present our report on whether Physician Assistants (PAs) should be regulated under the *Regulated Health Professions Act, 1991* (RHPA). Our recommendation recognizes the evolving role of PAs in Ontario and the importance of protecting both patients and the public.

As part of our standard process, we completed literature, jurisdiction and jurisprudence reviews, and conducted a consultation program, during which we heard from a broad range of stakeholders, including members of the profession, associations and key stakeholders such as the College of Physicians and Surgeons of Ontario.

The consultation highlighted the need to understand the ways in which PAs can supplement the supply of physician-based services in high-demand areas, such as emergency departments. It also outlined the current positive contributions of PAs to multi-disciplinary teams in various health care settings.

In considering this request, we took into account the relative infancy of the profession in Ontario (although it has had a long and successful history in the Canadian Forces and in the United States). We also noted the lack of relevant available research related to risk of harm in the practice of the PA profession.

This application did not meet our primary criterion threshold for risk of harm, thereby making an assessment of the secondary criteria unnecessary. The recommendation was based on the information available to us during the referral period. We recognize, however, that with the implementation of targeted PA initiatives in Ontario, further evidence may become available over time. At the minister's discretion, representatives from the PA profession may submit a revised request for regulation when relevant evidence demonstrating that the risk of harm threshold has been met becomes available.

We look forward to meeting with you to discuss the findings in this report and our recommendations.

Sincerely,

<i>Original signed by</i> <hr/> Thomas Corcoran, Chair	
<i>Original signed by</i> <hr/> Bob Carman, Member	<i>Original signed by</i> <hr/> Rex Roman, Member
<i>Original signed by</i> <hr/> Said Tsouli, Member	<i>Original signed by</i> <hr/> Peggy Taillon, Member

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Report by the Health Professions Regulatory Advisory Council

August 2012

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Executive Summary

In a referral letter dated June 24, 2011, The Honourable Deb Matthews, Minister of Health and Long-Term Care, asked the Health Professions Regulatory Advisory Council (HPRAC) to advise whether the Physician Assistant (PA) profession should be regulated in Ontario under the *Regulated Health Professions Act, 1991* (RHPA), and, “if so, what would be the appropriate scope of practice, controlled acts and titles authorized to the profession.” The minister also asked HPRAC to consider what form of regulation, if any, would be the most effective in strengthening interprofessional collaboration (IPC) between PAs and other health professions.

The PA role is new in Canada. In the fall of 2005, just 130 PAs were practising in this country, most of them in the Canadian Forces, which has trained and employed PAs for over 40 years. The Canadian Forces has been instrumental in growing the civilian PA profession nationally, through promoting the certification of PAs and the accreditation of educational programs. In June 2003, the Canadian Medical Association (CMA) recognized PAs as health professionals. Soon after, the first accredited educational program opened its doors, in June 2004.

Although PAs practise with varying degrees of direction, the profession is structured such that a PA will always require supervision by a physician. The level of supervision is negotiated on an individual basis, between each PA and his or her supervising physician.

The Government of Ontario is committed to improving the quality of health care delivery in Ontario, using the best evidence to drive change, and to fostering a greater degree of IPC among health care professionals in Ontario. This agenda is driven by identified trends that are having a significant impact on the province’s health care system—our aging population, increased costs and an overall increase in chronic diseases among Ontarians—and thus the need for a health care system that is increasingly focused on efficiency and effectiveness. The Ministry of Health and Long-Term Care has stated that the use of PAs can help improve access and reduce wait times in an era of limited human and financial resources.

HPRAC invited the Canadian Association of Physician Assistants (CAPA), the PAs’ national association, to submit an application to regulate PAs under the RHPA. In January 2012, CAPA submitted that application.

This report outlines the results of HPRAC’s review of CAPA’s application and the additional information available at this time. HPRAC’s criteria are the means by which it decides whether to recommend a health profession for regulation. Applicants from professions seeking regulation under the RHPA must meet a “risk of harm threshold” and demonstrate with evidence that there is a risk to the public and that it is otherwise in the public interest that the particular profession be regulated under the RHPA. HPRAC then considers whether it should recommend regulating a profession (or recommend other mitigating measures) for a profession that it has determined is posing a risk of harm to the public.

As part of its assessment, HPRAC also conducted an extensive public consultation program between January and March 2012, asking a number of organizations and individuals to comment on the issue. The program brought in a total of 72 responses. Key informant interviews were also

conducted, in order to identify stakeholders' interests and concerns early in the consultation process.

As well, HPRAC considered the feasibility, applicability, potential benefits and risks of a range of regulatory options, and reflected on guidance from other jurisdictions, such as the United Kingdom, where PAs have recently been introduced, and the United States, where the PA profession is much older, larger and more integrated into the health care system.

The principle guiding HPRAC's recommendation is whether the submission met the risk of harm threshold. Based on HPRAC's criteria, the submission and additional information available at this time, there is insufficient evidence to meet the risk of harm threshold. HPRAC therefore recommends that:

1. Physician assistants not be regulated under the *Regulated Health Professions Act, 1991* (RHPA) at this time;
2. A compulsory registry be implemented under the governance and oversight of the College of Physicians and Surgeons of Ontario (CPSO); and
3. Interprofessional collaboration between PAs and other health professionals be enhanced as a by-product of the registry, through encouraging the growth of the profession in Ontario and by instilling confidence among regulators and the practice community about PAs' qualifications.

Regulatory oversight must be proportional to risk and promote safe, effective and patient-centred health care, clearly and simply. It should be emphasized that HPRAC's review process did not include an assessment of the merits of the profession seeking regulation. Over time, as Ontario's PA initiatives gain traction, the profession grows and relevant evidence becomes available, the regulatory landscape may change.

Chapter I: Recommendation

The Health Professions Regulatory Advisory Council (HPRAC) recognizes the need for extending and supporting regulated health professionals with resources such as physician assistants (PA). Within this context, after careful review of the application provided by the Canadian Association of Physician Assistants (CAPA) and additional information available at this time, and using HPRAC's published criteria and process, HPRAC recommends that:

1. Physician assistants not be regulated under the *Regulated Health Professions Act, 1991* (RHPA) at this time;
2. A compulsory registry be implemented under the governance and oversight of the College of Physicians and Surgeons of Ontario (CPSO); and
3. Interprofessional collaboration between PAs and other health professionals be enhanced as a by-product of the registry, through encouraging the growth of the profession in Ontario and by instilling confidence among regulators and the practice community about PAs' qualifications.

Why This Decision?

The principle guiding this recommendation is whether the submission met the risk of harm threshold. Based on HPRAC criteria, the submission and additional information available at this time, there is insufficient evidence to meet the risk of harm threshold.

At the minister's discretion, representatives from the PA profession may submit a revised request for regulation when relevant evidence demonstrating that the risk of harm threshold has been met becomes available.

HPRAC proposes that the PA profession in Ontario build on the existing certification process to increase certainty regarding the assurance of practitioners' qualifications. HPRAC acknowledges that registry models can have varying degrees of complexity, and therefore recommends a compulsory registry to ensure that all PAs delivering patient care in Ontario meet standard entry-to-practice competencies and professional development requirements.

Chapter II: Background

Referral Question

The Minister of Health and Long-Term Care, The Honourable Deb Matthews, asked HPRAC¹ to advise whether the practice of Physician Assistants (PAs) should be regulated in Ontario. In an April 19, 2011, letter to HPRAC, the minister noted that she would be “asking the Advisory Council to consider whether public safety and quality of care would be sufficiently upheld in the long term via this delegation model or if a new formal regulatory structure should be put in place through which Physician Assistants would be regulated.”

In a subsequent letter, the referral letter, dated June 24, 2011, the minister further stated that, “In keeping with this government’s health quality agenda, I would like you to consider whether [the PA] profession ought to be regulated, whether independently or in conjunction with an existing profession, under the *Regulated Health Professions Act, 1991* (RHPA) and if so, what would be the appropriate scope of practice, controlled acts and titles authorized to the profession. I would also like you to consider in the formation of your advice, what model of regulation, if any, is most conducive to interprofessional collaboration. In evaluating potential models of regulation, consider what factors would support effective future collaboration between PAs and other health professions in Ontario.”

HPRAC invited the Canadian Association of Physician Assistants (CAPA) to submit an application to regulate PAs under the RHPA. In January 2012, CAPA submitted that application.

Delivering Health Care in Ontario: Evolving Priorities

Ontario’s 2012 *Action Plan to Transform Health Care* identified trends that are having a significant impact on our health care system. The report highlighted how demographic challenges will drive the need for services and increase costs: “If we did not change anything, kept the age-specific costs what they are today and applied them to the 2030 population, our health costs would increase by \$24 billion—50 per cent more than today from changing demographics alone.”²

In addition, the Drummond Report included key recommendations on how to make long-term, fundamental changes in the way government delivers services. It also emphasized the need for

¹ For more information on HPRAC and its mandate, see Appendix A. To view CAPA’s application, see Appendix C.

² Ministry of Health and Long-Term Care (MOHLTC), *Ontario’s Action Plan for Health Care*, (2012), http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf.

team-based interdisciplinary health care that both maximizes the role of non-physician health care providers and lessens the pressure on physicians.³

This environment, combined with overall increases in chronic diseases, means that more people will need direct and preventative care within a patient-centred health care system that is increasingly focused on efficiency and effectiveness. The introduction of new technologies, medical advances and interprofessional teams, among other factors, will continue to challenge the way health care is delivered, the number of health care providers needed to meet these needs and the skills that providers must possess.

Many jurisdictions (in Canada and internationally) have developed assistant and mid-level practitioner roles to support their challenging environments. In the United States, for example, a PA practice that supports and extends the physicians' practice has evolved over time and improves access to care; at the same time, safety and quality of care have been maintained, if not improved.⁴

Physician Assistants in the United States

The Physician Assistant role is much better established in the United States than in any other jurisdiction. From its origins in the military and then in primary care settings, the role has further expanded into specialty areas such as emergency departments (EDs), orthopedics and dermatology. Over the past 10 years, the number of mid-level practitioners (MLPs),⁵ including PAs, has increased dramatically: the data suggest that they represent one-sixth of the total U.S. medical workforce.⁶ In response, the number of training programs has multiplied and cost-containing efforts have intensified. The U.S. Bureau of Labor Statistics projects that there will be a 50% increase in the number of PAs from 2004 to 2014, making it the fourth-fastest-growing profession in the United States.⁷

Canadian and U.S. PAs share many of the same duties within a multi-disciplinary team, including:⁸

- assuming certain tasks, to free up physician time (e.g., supporting patient self-management);
- increasing patient communication (e.g., helping patients understand medication directions, side effects of treatment, etc.); and

³ Ontario Ministry of Finance, Commission on the Reform of Ontario's Public Services, *Public Service for Ontarians: A Path to Sustainability and Excellence* (The Drummond Report) (2012), <http://www.fin.gov.on.ca/en/reformcommission>.

⁴ Jennifer Fisher Wilson, "Primary Care Delivery Changes as Nonphysician Clinicians Gain Independence," *American College of Physicians: Annals of Internal Medicine* 149, no. 8 (2008): 598-600.

⁵ The World Health Organization defines mid-level practitioners as "front-line health workers in the community who are not doctors, but who have been trained to diagnose and treat common health problems, to manage emergencies, to refer appropriately, and to transfer the seriously ill or injured for further care (WHO/WPRO, 2001:1).

⁶ Spencer Dorn, "Mid-Level Providers in Gastroenterology," *American Journal of Gastroenterology* 105(2): 246-51 (Feb 2010).

⁷ Ibid.

⁸ Ibid.

- providing routine, protocol-guided patient care that can be increased if required.

A recent study in the *American Journal of Gastroenterology* indicated that, within academic health centres, the main reasons for hiring MLPs were:⁹

- resident duty-hour restrictions (26.9%)
- increasing patient throughput (88.8%)
- increasing patient access (77%)
- improving patient safety/quality (77%)
- reducing patient length of stay (73%)
- improving continuity of care (73%)

The American approach to utilizing PAs can be summed up in a recent article published in the *American Journal of Gastroenterology*: “In total, by bettering supporting patient self-management and by increasing the quantity and quality of available services, incorporating MLPs into multidisciplinary teams may be an extremely cost-effective means of improving health outcomes.”¹⁰

Physician Assistants in Ontario

An environmental scan conducted by staff at the Health Human Resources Policy Branch, Ministry of Health and Long-Term Care (MOHLTC), reported that approximately 130 PAs were practising in Canada in the fall of 2005.¹¹ Most of the PAs worked for the Canadian Forces, which has trained and employed physician assistants for over 40 years. In the military, the demand for PAs originated in battlefields and sick bays, and so Forces-trained PAs developed skills to meet these unique military needs. The non-military use of PAs was later inspired by the U.S. experience. In that country, civilian PAs have been well established for decades. The Canadian Forces has been instrumental in growing the civilian PA profession nationally, by educating the civilian hospital sector as well as promoting the accreditation of educational programs and the certification of PAs.¹²

With the support and assistance of the Department of National Defence, the Canadian Academy of Physician Assistants (now the Canadian Association of Physician Assistants [CAPA]) was created in 1999. Its membership has grown to include more than 400 practising and student PAs.¹³ The organization’s mandate is to advance the PA profession in Canada; its mission is to “foster development of the physician assistant model to ensure quality care for Canadians; and improve access to that quality medical care.”¹⁴

⁹ Marc Moote, Cathleem Srsek, Ruth Kleinpell and Barbara Todd, “Physician Assistant and Nurse Practitioner Utilization in Academic Medical Centres,” *American Journal of Medical Quality*, vol. 26, no. 6 (2011), 452-60.

¹⁰ Dorn, op. cit.

¹¹ HealthForceOntario, *Introducing Physician Assistants in Ontario*, December 2008, p. 7.

¹² Commodore Hans W. Jung, “The Birth of Physician Assistants in Canada,” *Canadian Family Physician* (2011), <http://www.cfp.ca/content/57/3/275.full>.

¹³ Canadian Association of Physician Assistants, *The Canadian Association of Physician Assistants’ Application for Regulation of the Physician Assistant Profession in Ontario* (January 2012), p. 23.

¹⁴ CAPA, “Mission and Vision,” (2012), http://capa-acam.ca/en/Mission__Vision_23.

In June 2003, the CMA recognized PAs as health professionals. This was a necessary first step towards the accreditation of educational programs. The Canadian Forces Health Services School PA education program came onboard first, in June 2004,¹⁵ followed in 2008 by the University of Manitoba Physician Assistant Education Program and the McMaster University Physician Assistant Education Program.¹⁶ The Consortium of PA Education (which was collaboratively formed by the University of Toronto, the Northern Ontario School of Medicine and the Michener Institute for Applied Health Sciences) started a third civilian PA program in January 2010.¹⁷ An August 2012 publication indicates that Ontario's PA programs have already graduated 62 PAs and that approximately 45 PAs are expected to graduate every year.¹⁸ The PA profession is small and is expected to remain small for some time.

The Ministry of Health and Long-Term Care has stated that the use of PAs can help improve access and reduce wait times in an era of limited human and financial resources. As part of a 2006 HealthForceOntario strategy, a series of PA initiatives were launched, co-led by MOHLTC and the Ontario Medical Association (OMA). The initiatives focus on how to further integrate PAs into the health care system, and highlight the settings in which PAs can have the greatest impact and/or be the most cost effective. The goal was to inform long-term integration plans about a safe and effective way to reduce wait times and improve patient satisfaction.¹⁹ See Chapter IV, "PA Initiatives in Ontario," for more information on the PA initiatives and demonstration projects.

HPRAC's Criteria

HPRAC recently reviewed its assessment criteria and determined that the existing decision-making framework was relevant and valid. The process was updated, however, to address access to care, health outcomes, interprofessional collaboration, health human resource productivity and labour mobility.

For referrals, the **primary criterion** addresses whether the health profession seeking regulation poses a risk of harm to the health and safety of the public. The criterion acts as a gating mechanism: the applicant must present a solid, evidence-based argument, based on a preponderance of evidence, that there is a risk of harm to the public before its application moves to the next level. Once an applicant meets the primary criterion threshold, it is then assessed on the extent to which it meets the **secondary criteria**. HPRAC applies the secondary criteria to

¹⁵ CAPA, "History" (2012), http://capa-acam.ca/en/History_50

¹⁶ Canadian Medical Association (CMA), *2nd National Physician Assistant Symposium, Summary of Proceedings* (2009), http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Advocacy/Physician_Assistants/2008_symposium/National-PA-symp2008_e.pdf

¹⁷ CMA, *Physician Assistant Toolkit* (2010), p. 18, http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Advocacy/Physician_Assistants/PA-Toolkit_en.pdf#page=20

¹⁸ HealthForceOntario, *HFO Radius*, Issue 9 (August 2012), <http://www.healthforceontario.ca/upload/en/whatishfo/hfo-radius-august-2012-en.pdf>

¹⁹ MOHLTC, "Ontario's Physician Assistant Initiative," *HPRAC Briefing Regarding PA Regulation* (March 2012).

determine whether regulation under the RHPA is the most appropriate course of action or whether another approach to risk mitigation would be a better outcome. This level of assessment focuses on profession-specific factors and assesses whether regulation under RHPA is, in fact, the best way to protect the public.

To assist applicants, HPRAC has produced a process and criteria guide, *Regulation of a New Health Profession under the Regulated Health Professions Act, (RHPA), 1991: Criteria and Process*. See Volume 2 for more information on HPRAC's criteria and process, and Chapter V, "Rationale," for information on how the criteria were applied to the application.

Chapter Summary

HPRAC reviewed the minister's referral in the context of the needs of Ontario's health care system, now and into the future. The PA profession is currently being introduced in Ontario outside of the military milieu within which it has historically existed. PAs and other mid-level practitioners bring a variety of benefits to the health care table, many of which address some of the gaps identified in the efficient delivery of services.

With respect to the PA referral and all other referrals regarding the regulation of a profession, HPRAC's criteria and process form the basis of its decision-making.

Chapter III: What We Heard

For all referrals, HPRAC engages in broad-based consultation that seeks stakeholder input to help develop its recommendations to the Minister of Health and Long-Term Care. Upon receipt of the PA referral from the minister, HPRAC began determining relevant public interest concerns and questions and attempting to understand all perspectives on the issue, including those of key health care practitioners, other affected health care professionals, clients, patients, advocates and regulators. The issue then proceeded through a multi-stage process in which information and responses were both requested from and shared with stakeholders.

Consultation Program

HPRAC conducted an extensive public consultation program from January to March 2012. To ensure that the broader community of interest had the opportunity to participate in this referral, HPRAC asked a number of groups/organizations and individuals to comment on the issue, including:

- regulatory health colleges
- regulated health profession associations
- regulated health care professionals
- academics and subject matter experts with an interest and/or expertise in the regulation of health professions
- organizations/groups with an interest in the regulation of health professionals
- local health integration networks (LHINs)
- the public

HPRAC's website was the main communications vehicle for the consultation process. Relevant background material was posted on its physician assistants' referral page²⁰ and the public was invited to comment on a series of questions on the PA profession related to risk of harm and public interest concerns. Comments were posted for public review each week. The survey questions were based on HPRAC's process and criteria guide.²¹ Submissions to the site were reviewed regularly so that HPRAC could determine key themes²² and highlight potential issues vis-à-vis the regulation of the practice of PAs.

²⁰ See <http://www.hprac.org/en/projects/physicianassistants.asp>

²¹ See http://www.hprac.org/en/projects/resources/RegulatingaNewProfession_CriteriaProcess_Nov2011.pdf or Volume 2. See Appendix B for consultation questions.

²² HPRAC's goal for the consultation process was to uncover both broad themes and unanticipated issues, not to create a quantitative source of stakeholder interests or concerns.

The consultation program received 72 responses:

- 49 from individuals, including physician assistant students, academics, unregulated health professionals and regulated health professionals such as medical radiation technologists, physicians and nurse practitioners; and
- 23 from organizations, including professional associations (11), regulatory colleges (5), the military (1) and other interested organizations (6).

Participants were asked, among other things, whether the applicant had demonstrated that the practice of PAs could pose a risk of harm to the health and safety of the public, and whether there was adequate evidence to support regulation. A variety of responses were submitted. Table 1 summarizes the key recommendations and themes gathered through the consultation.

Table 1. Consultation Submissions: Key Recommendations and Themes

Area of Risk: Primary Criterion²³	Summary of Comments Supporting Regulation	Summary of Comments Opposing Regulation	Area of Risk: Secondary Criteria²⁴
Adequacy of supervision	Proper oversight of professional conduct, the supervisory relationship and standards of practice require the rigour of regulation. An undue burden is placed on the supervising physician regarding oversight of PA professionalism.	Oversight provided by the CPSO (College of Physicians and Surgeons of Ontario) is comprehensive, adequate and appropriate, both implicitly and explicitly. There is no indication that regulation will materially change the current supervisory structure.	Appropriateness of regulatory mechanism
Likelihood of high risk	PA autonomy, and access to a broad range of controlled acts, is inherently risky.	There is inadequate evidence, very little Ontario-based information and no complaints data to show that there is a risk of harm in the absence of regulation. A proportionally small risk is associated with the (small) size of the profession.	Impact of scope of practice
Ability to identify qualified practitioners	Title protection, as provided by regulation, is essential in protecting the public from unqualified individuals.	Other regulatory options can, to some degree, address public protection mechanisms, including title protection.	Non-statutory regulatory regime options

²³ The primary risk of harm themes are based on aspects of HPRAC's criteria.

²⁴ The secondary risk of harm themes are based on aspects of HPRAC's criteria.

Public need for regulation	PAs are an important health system resource and would be better utilized in terms of health care productivity and interprofessional care (IPC) ²⁵ if the profession could obtain the uniformity and status of regulation.	Uniformity is not a reasonable outcome of regulation: PAs do not have a defined body of knowledge. Each PA utilizes his/her job description in place of a profession-wide scope of practice, as the PA's scope of practice mirrors that of his/her supervising physician. The health care system would be more efficiently maximized by optimizing the competencies of existing qualified health professionals who are capable of undertaking the same work. Furthermore, regulation would be costly to the system due to restructured physician fee schedules, test ordering and other obscured costs.	Various economic impacts. Access to care.
Severity of risk	The profession is well organized and includes accredited education programs, development of national competencies, certification requirements and continuing professional development.	The profession has not demonstrated a readiness for regulation. No budget or fee structure was proposed to support regulation under the RHPA. The PA practice is similar to that of NPs (nurse practitioners), although training is considerably less rigorous.	Membership's support for regulation. Adequacy of educational programs

Key Informant Interviews

A number of key informant interviews were conducted, in order to identify stakeholders' interests and concerns early in the consultation process. Meetings with persons or organizations with an identified expertise or stake in the issue were held. In considering the application for regulation of the PA profession, HPRAC conducted interviews with the following organizations:

- Canadian Association of Physician Assistants (CAPA)—Valoree McKay (Executive Director) and Tim Ralph (President)
- Canadian Forces (CF) Health Services Group—Commodore H.W. Jung (Surgeon General/Commander)

²⁵ See Chapter VI: Other Considerations, for information on IPC and the PA profession.

- College of Physiotherapists of Ontario—Shenda Tanchak (Registrar and CEO), Rod Hamilton (Associate Registrar) and Shari Hughes (Associate Registrar)
- Health Human Resources Policy Branch, MOHLTC—Jeff Goodyear (Director)
- Health Sector Labour Market Policy Branch, MOHLTC—Christy Hackney (Manager)
- Nurse Practitioners' Association of Ontario (NPAO)—Theresa Agnew (Former Membership Relations staff) and Daria Parsons (Executive Director)
- University of Manitoba Physician Assistant Education Program—Ian Jones (Program Director)
- Registered Nurses' Association of Ontario—Doris Grinspun (CEO)
- Sunnybrook Health Sciences Centre—Dr. Paul Hawkins (Medical Director, Clinical Operations)

Key Stakeholders

The applicant proposed CPSO as its regulatory vehicle, and thus the comments submitted by CPSO during the consultation provided an important insight into the proposal. Although CPSO recognizes that regulation under the RHPA may be appropriate in the long term, it also offered a menu of regulatory options, including non-statutory options tailored to the size of the profession and the risk of harm level. For example, CPSO stated that, “In our view, it would be unwise to create a full regulatory scheme for such a small group of practitioners....We recommend a progression from a PA registry approach to more comprehensive regulation only at the point when PA volume reaches levels where risk cannot otherwise be mitigated.”²⁶

Chapter Summary

Many of the comments gathered through the consultation program identified the same issue: the lack of relevant evidence available at this time to adequately identify risk of harm to the public. This may be due, in part, to the newness of the profession in Canada and the low number of PAs in Ontario—despite a significant history of practice in the military and the United States. This lack of evidence may have had an impact on the number of submissions to HPRAC from individuals and other regulated health professionals.

Some submissions noted how difficult it was to comment, because of the lack of information available to them or because of deferral to key professional groups. For example, the College of Chiropodists of Ontario, the Ontario Podiatric Medical Association and the Ontario Society of Chiropractors noted that, “Since Physician Assistants are able to practise only with a supervising physicians, pursuant to which the supervising physician delegates patient care responsibilities to the PA, we defer to the physician community to determine the best mode and mechanisms of regulation to protect the public interest.”²⁷

²⁶ HPRAC, *Stakeholder Feedback on the Regulation of Physician Assistants under the Regulated Health Professions Act, 1991 (RHPA): Responses from Organizations* (2012), <http://www.hprac.org/en/projects/resources/PA-Orgsub1-AsofMarch30a.pdf>

²⁷ Ibid.

Chapter IV: What We learned

Three major reviews were completed in support of HPRAC's recommendation. Information from these reviews was made publicly available during the consultation period. For the full text of these reviews, see Volume 2.

Additional research was conducted by HPRAC on a wide range of topics to better understand the risk of harm and public interest issues related to physician assistants in Ontario.

Jurisprudence Review

HPRAC undertook a jurisprudence review that explored legal cases relevant to the PA profession.

Unlike in the United States, where the PA profession is highly developed, the profession is in its early stages of development outside of the military in Canada, as well as in other countries. As a result, all of the cases in the review are from jurisdictions in the United States.

The legal cases dealt with issues such as PAs misusing their power in order to engage in a sexual relationship with a patient, misdiagnosing conditions, providing sub-standard care (in particular, inappropriately prescribing medication) and practising outside of their scope of practice.

Additional CPSO Enquiry

In order to better understand the risk of harm, HPRAC requested information from CPSO on complaints received about delegation and, in particular, the supervision of activities delegated to PAs. CPSO reported that it received 29 delegation-related complaints between 2006 and 2010, and that only one case involved a PA. Drawing any conclusion is difficult because of the low number of PAs practising in Ontario during that period.

Jurisdictional Review

HPRAC also conducted a jurisdictional review of the regulation of PAs in select Canadian provinces and American states, the United Kingdom (U.K.), South Africa and Australia. This review created a broader context through which HPRAC could understand how other jurisdictions regulate the PA profession.

The United States has the most established regulatory system for PAs. All 50 states regulate PAs through one of three models:

1. regulation by the state's medical board
2. regulation by a PA advisory committee/council operating under the state's medical board
3. regulation by PA board/task force that is independent of the state's medical board

Regulatory tools in the United States vary between jurisdictions. For example, some jurisdictions use a list of acts that the PA is restricted from performing. Others simply state that PAs may only

provide medical services in those areas where the supervising physician provides patient care. Within the jurisdictions HPRAC reviewed, legislation governing PAs adheres to a physician-delegated scope of practice, on the condition that the delegated duties are within the PA's scope of education and training. As well, a physician may not delegate tasks to a PA that the physician is not permitted to perform. In some jurisdictions, a "practice description," setting out the medical services a PA may perform, must be approved by the governing body before a PA may practise. In other jurisdictions, a checklist specifies which duties a PA may perform.

All of the American jurisdictions HPRAC reviewed have the same basic registration requirements as Canada (i.e., graduation from an accredited or approved PA educational program, and certification). There are some differences, however, in the requirements to maintain certification.

Of the three international jurisdictions reviewed, only South Africa formally regulates PAs. The U.K. uses a voluntary registry model that is managed by the U.K. Association for Physician Assistants, which is not a regulatory body.

In Canada, PAs are statutorily regulated in two provinces—Manitoba and New Brunswick. In both of these jurisdictions, PAs are regulated under each province's College of Physicians and Surgeons and must be registered in order to practice. Alberta uses a voluntary (i.e., non-regulated) registry, which is held by the College of Physicians and Surgeons of Alberta. (For more information on registries, see Chapter VI: Other Considerations.)

The number of PAs practising across Canada is low. The review noted that, at the time the research was conducted, there were 10 PAs practising in Alberta, 26 in Manitoba and two in New Brunswick.

In Canadian jurisdictions, to qualify for registration or listing on the registry, PAs must obtain certification by the Physician Assistants Certification Council of Canada (PACCC). In order to become certified, a PA must:

1. have graduated from a recognized PA training program,
2. pass the PA certification exam, and
3. be a member of CAPA

Because of the voluntary nature of the Alberta registry, Alberta PAs are not required to be listed on it in order to practice.

Since all PAs are supervised by physicians, they may work in any medical setting in which their supervising physicians practise. In some jurisdictions, the settings in which a PA may practise are legislated. In Manitoba, the practice locations of PAs must be submitted and approved by the College of Physicians and Surgeons. The level and type of supervision are determined by the practice setting and by the PA's experience. In general, the amount of PA oversight is a matter of "negotiated autonomy."²⁸

²⁸ David E. Mittman, James F. Cawley, & William H. Feen, "Physician Assistants in the US," *BMJ*, 325(7362): 485–7.

Literature Review

HPRAC commissioned a literature review that was completed in August 2011. The review's objectives were to investigate:

1. the impact of PAs on patient safety and risk of harm,
2. the degree of autonomy of practice granted to PAs, and
3. the degree to which PAs have been shown to collaborate with other practitioners in teams

Because of the newness of the profession outside of the military in Canada, the review found limited information on PAs' safety, cost effectiveness, autonomy and interprofessional collaboration activity. Most literature looked only at the collaborative relationship between PAs and their supervising physicians. The research literature is also sparse, suffers from a number of research methodology limitations and is mostly from the United States. It often groups PAs with nurse practitioners (NPs) and refers to them as mid-level providers (MLPs).

The review generally found that the care provided by PAs is equivalent to that provided by physicians in terms of safety, and that complication rates between PAs and physicians were comparable.

In terms of autonomy, the review found that it varied by jurisdiction and by clinical setting. For example, PAs working in rural settings spend less time with their supervising physicians and have a broader scope of practice than their urban counterparts. A number of other factors also influence autonomy levels, including the PA's experience, training and competence; requirements of the PA's employers; and the setting in which PAs practise (i.e., rural vs. urban).

In addition to the major literature review, a supplementary review of the literature was undertaken to assess items published after August 2011. Included in the review was the draft evaluation report of the demonstration projects, the *Ontario Physician Assistant Implementation—Report of the Evaluation Subcommittee*. See "PA Initiatives in Ontario," below, for a discussion of some of the results of this report and Chapter V: Rationale, for a discussion of other results.

PA Initiatives in Ontario

In anticipation of Ontario's evolving health care needs and as part of its quality improvement initiatives, the PA role was announced in May 2006.²⁹ Building on the experience of other jurisdictions where PAs have been shown to be effective in reducing wait times and improving patient satisfaction,³⁰ a series of projects was launched to enable long-term decision-making and

²⁹ HealthForceOntario, "Physicians Assistants: Frequently Asked Questions," <http://www.healthforceontario.ca/WhatIsHFO/FAQs/PhysicianAssistants.aspx>

³⁰ HealthForceOntario, *Introducing Physician Assistants in Ontario*, December 2008, p. 25.

introduce the role to the health care system. The initiatives were designed to assess the most effective use of PAs in Ontario's health care system.³¹

Component 1 involved introducing the PA role into different clinical settings. This implementation occurred in three phases:

1. emergency department one-year pilot (2007)
2. demonstration projects in several settings (2008 to now)
3. emergency department expansion and primary care (family health teams [FHTs], 2009 to the present)

Component 2 involved developing the PA education programs in Ontario at:

- McMaster University (which began in September 2008); and
- the University of Toronto (with the Northern Ontario School of Medicine and the Michener Institute for Applied Health Sciences, which began in January 2010)

Approximately 110 practising PAs have now been introduced across the health care system at more than 70 sites.³² For example, 2011's 41 PA graduates are working in 20 different cities within 13 (of 14) LHINs in the following practice areas:³³

- primary health care
- internal medicine
- emergency medicine
- complex continuing care
- orthopedics
- other practice/clinical specialties

The demonstration projects (Component 1) had extensive stakeholder support. The projects were co-led by MOHLTC and OMA and guided by committees of employers, regulators and health professionals. Other key stakeholders heavily involved in the project included the Ontario Hospital Association (OHA), the Association of Ontario Health Centres (AOHC) and CPSO.

In addition to the major literature review described in the "Literature Review" section, above, a small-scale review was also undertaken. This review assessed items published after August 2011, once the initial literature review had closed. Included in the review, and of considerable interest to HPRAC, was the draft evaluation report of the demonstration projects, the *Ontario Physician Assistant Implementation—Report of the Evaluation Subcommittee*.

To determine the value of the PA role in the Ontario health care system, PA performance in a variety of clinical settings was assessed primarily in qualitative terms. Using dimensions such as access, efficiency, effectiveness, quality/safety and sustainability, the evaluation focused on the impact of introducing PAs to the system. It did not make comparisons between the impact of PAs and other non-physician practitioners, and it did not evaluate the cost effectiveness of PAs.

³¹ Ibid.

³² Jeff Goodyear, "Ontario's Physician Assistant Initiative," *HPRAC Briefing regarding PA Regulation* (March 2012).

³³ HealthForceOntario, *HFO Radius*.

The report noted the difficulty in trying to understand the impact of the PA role within a health care framework that has recently undergone a variety of changes. The quantitative data presented in the report were limited, but did measure positive impacts of the PA role, such as reduced wait times for emergency department patients.

One of the evaluative dimensions addressed “the ability for clients/patients/staff to not be harmed by an accident or mistakes when receiving or providing care.”³⁴ Although survey findings indicated a positive impact on patient safety and quality of patient outcomes, the evidence did not include any direct measurement of changes in patient safety. Overall, findings in the (draft) report did not include strong quantitative evidence related to risk of patient harm.

The applicant described ongoing, supportive relations with high-profile, affiliated organizations, noting that CMA and OMA “are strong supporters for the integration of PAs into the Canadian health care system and for the regulation of the PA profession in Ontario.”³⁵ These organizations have contributed to the establishment of the profession in practical and necessary ways; OMA, for example, took a leadership role with MOHLTC in the demonstration projects, and CMA worked with CAPA in a leadership capacity for the accreditation of the Canadian PA academic programs. The College of Family Physicians Canada (CFPC) allows PAs to track continuing education credits through a portal on its website.³⁶ The Ontario Minister of Health and Long-Term Care recognized PAs as having a “crucial and significant role in Ontario’s health system” and that “through a collaborative and patient-centred approach physician assistants are improving health care in Ontario.”³⁷

Some anecdotal concerns were raised through key informant interviews and consultation comments that question whether demonstration project funding may be distorting the uptake and integration of PAs into Ontario’s health system.³⁸ It is unclear whether the profession will continue to grow at the close of the demonstration projects. Physicians who participated in the projects indicated that funding and grants were “highly influential” in their decision to hire a PA and that they would be unlikely to hire a PA if no government funding was provided.³⁹ As well, little or no information is available in the literature that evaluates the cost effectiveness of introducing PAs in Ontario.⁴⁰

³⁴ *Ontario Physician Assistant Implementation: Report of the Evaluation Subcommittee* (draft), December 2011, p. 33.

³⁵ CAPA application (see Appendix C), p. 25.

³⁶ CAPA application, (see Appendix C), p. 17.

³⁷ Letter from Minister of Health and Long-Term Care to “friends” regarding National Physician Assistant Day (undated).

³⁸ HPRAC, *Stakeholder Feedback on the Regulation of Physician Assistants under the Regulated Health Professions Act, 1991 (RHPA): Responses from Organizations*.

³⁹ Chan Kulatunga-Moruzi, *The Integration of the Inaugural Graduates of the McMaster University Physician Assistant Education Program Into Ontario's Health Care System—Report* (2011), http://rorrhts-ohhrrn.ca/index.php?option=com_content&view=article&id=156&Itemid=42&lang=fr.

⁴⁰ Centre for Health Economics and Policy Analysis (CHEPA), *Economic Analysis of Physician Assistants in Ontario: Literature Review and Feasibility Study* (2011), CHEPA Working Paper Series, Paper 11-03, <http://www.chepa.org/docs/working-papers/chepa-wp-11-03.pdf?sfvrsn=2>.

Education and Ongoing Training

The applicant noted that PAs are trained as generalists. PA education programs are based on the medical model, which promotes alignment with the physician's practice. In Ontario, all three educational programs (at McMaster University, the CF Health Services Training Centre and the PA Consortium) are accredited by CMA and based on national competency standards. These two-year programs focus on "understanding the pathophysiology of disease, differential diagnosis determination, and treatment plan development. The programs include one year of clinical rotation in areas such as emergency medicine, pediatrics, internal medicine, orthopedics, sports medicine, general surgery, urology, anesthesia, trauma team and family practice."⁴¹ The first PA class in Ontario graduated in 2010.

The accredited educational programs ensure that PAs share a general body of knowledge and achieve a standard competence level at entry to practice. However, PA skills and abilities are expected to grow at varying rates, based on each PA's work experience and supervisory relationship. The growth in PA competencies to reflect the supervising physician's competencies is inherent to the PA profession, based on its structure, and is the product of the educational preparation and required, ongoing on-the-job training.

Key informants highlighted the point that while a general scope of practice may exist, each PA's scope of practice is unique and based on the supervisory relationship, level of autonomy and delegation of various controlled acts.

The Costs of Statutory Regulation

In general, the costs of the statutory professional regulatory system in Ontario—to the professional, to the employer and to the taxpayer—are significant. All regulatory colleges carry out core functions of self-regulation but the costs per college vary, depending on such factors as the services offered to members and the cost of delivering services. For example, in 2011, the operational costs of the College of Dental Technologists of Ontario (which has 488 active members) were approximately \$676,000,⁴² the operational costs of the College of Denturists of Ontario (which has 744 members) were \$1,040,000⁴³ and, for the College of Midwives of Ontario (which has 461 active members), the operational costs were \$1.3 million.⁴⁴ These costs include staff salaries and benefits, communication materials, legal costs, rent, utilities and other items related to the operations of an organization.

⁴¹ CAPA, FAQ, <http://capa-acam.ca/features/faq>

⁴² College of Dental Technologists of Ontario, *Annual Report 2010-2011*, http://www.cdto.ca/Publications/AnnualReports/2010-2011_Annual_Report.pdf

⁴³ College of Denturists of Ontario, *Annual Report 2010-2011*, http://cdo.in1touch.org/document/423/2010-2011_Annual_Report.pdf

⁴⁴ College of Midwives of Ontario, *Annual Report 2010-2011*, <http://www.cmo.on.ca/documents/ANNUALREPORT2010-2011FINAL.pdf>

The costs and obligations of regulation extend well beyond the membership fees charged by a regulatory college, however, and include the financial and in-kind costs of undertaking statutory obligations and advancing the profession within a regulatory milieu. For example, a profession must be able to supply sufficient numbers of members for representation in elections, fully staff committees and perform all of its statutory obligations. Although the applicant requested to be regulated within CPSO and not as a self-regulated college, the costs of regulation remain high. The applicant has suggested that the Ontario government provide funds for the start-up costs related to regulation.⁴⁵ (Until a college starts to generate revenue—i.e., register members—these monies would be the only source of funding for the college.) It is not clear how much funding would be required or how long funding might last.

Chapter Summary

As noted in the consultation comments, HPRAC's three foundational reviews⁴⁶ (jurisprudence, jurisdictional and literature), as well as additional research, found that the PA profession is very new outside of the United States, which may be a factor in the lack of relevant evidence regarding risk of harm. The research also showed a wide variability in competencies between PAs across the profession, despite the general body of knowledge shared by all PAs at entry to practice. In general, it is difficult to draw conclusions from the available data.

HPRAC has reviewed reports that show a need for the types of services provided by PAs. HPRAC also reviewed qualitative evidence identified in its literature review that indicates that the practice of the PA profession can result in increased access to care and shorter wait times. Potential changes to the health care system may also open up the need for primary care providers such as PAs, especially in smaller centres. Support has been shown to the profession from some regulatory colleges and high-profile health care stakeholders such as OMA and MOHLTC.

⁴⁵ CAPA application (see Appendix C), p. 21.

⁴⁶ See Volume 2.

Chapter V: Rationale

In considering the referral question, HPRAC consulted a variety of sources of information, including the CAPA application and studies referenced within the application; HPRAC's jurisdictional, literature and jurisprudence reviews; a supplementary literature review for very recently published papers; comments submitted during the HPRAC consultation process; key informant interviews; and several MOHLTC branches.

Primary Criterion: Risk of Harm

As noted in Chapter II, in the “HPRAC's Criteria” section, HPRAC has developed a two-part assessment tool to determine if a health profession should be regulated. In fulfilling the primary criterion, applicants must demonstrate, using relevant, verifiable evidence, that the practice of the profession meets a risk of harm threshold before HPRAC applies the secondary criteria to the application.

HPRAC's primary criterion is defined in the following way:

The fundamental principle with respect to health profession regulation under the RHPA is the protection of the public from harm in the delivery of health care, premised on the fact that it is in the public interest to do so. As such, it is vital to demonstrate that the health profession seeking regulation under the RHPA poses a risk of harm to the health and safety of the public. The term risk of harm refers to actions where a substantial risk of physical or mental harm may result from the practice of the profession. This criterion is intended to provide a clear articulation of the degree of harm posed by the profession to the health and safety of the public. In addressing the risk of harm in this context, the applicant is asked to identify the risks associated with the practice of the profession concerned, as distinct from risks inherent in the area of health care within which the profession operates.⁴⁷

This primary criterion is intended to provide a clear articulation of the degree of harm posed by the profession to the health and safety of the public. In addressing the risk of harm, the applicant must identify the risks associated with the practice of the profession, not risks inherent in the area of health care within which the profession operates.

An Evidence-Based Approach

As part of HPRAC's deliberations and processes, and in keeping with the Minister of Health and Long-Term Care's requirements on decision making, HPRAC uses an evidence-based approach when formulating its recommendations for the minister's review. Applicants for regulation under

⁴⁷ HPRAC, *Regulation of a New Health Profession under the Regulated Health Professions Act (RHPA), 1991: Criteria and Process*, http://www.hprac.org/en/projects/resources/RegulatingaNewProfession_CriteriaProcess_Nov2011.pdf.

the RHPA must provide different types of evidence to inform the decision-making process. The type of evidence required will differ based on which criteria the proposal is addressing. To help applicants fulfill this requirement, HPRAC's criteria and process document⁴⁸ groups the types of evidence needed into a number of subject areas: research, knowledge/information and economics. Examples are provided for each area, so that applicants clearly understand how to support their application. These examples include empirical evidence from randomized control trials and other trials; analytic studies, such as cohort or case control studies; time series analyses; anecdotal evidence; qualitative evidence; before and after studies; surveys; the results of consultation processes with networks/groups; expert knowledge; grey literature; and financial sustainability studies.

Different study types comprise different degrees of structural rigour and address different aspects of a general scientific enquiry. A well-conducted randomized controlled trial, for example, offers compelling evidence of "whether a cause-effect relationship exists between treatment and outcome and for assessing the cost effectiveness of a treatment."⁴⁹ These studies are appropriately used in investigating some unknowns but cannot be used in all cases. Many other types of studies, when well conducted, are also important for applicants to include to help HPRAC understand as many aspects as possible regarding the profession's risk of harm. HPRAC also considers factors such as the quality of experimental design, scientific enquiries and study areas; ability to generalize the results; and other potential research limitations, because poor study design can produce inaccurate outcomes. HPRAC thoroughly considers and weighs all the evidence presented.

The literature review commissioned by HPRAC notes a lack of relevant available research and comments that, "The research literature...is sparse, and suffers from a series of limitations including small sample sizes, a lack of randomized controlled trials, and poor descriptions of study settings....Caution should be taken in interpreting the findings." The literature review also notes that the body of knowledge related to the PA practice is incomplete. There is, for example, "surprisingly little research on the impact of physician assistants on the quality of care and its outcomes."⁵⁰ A systematic review conducted in 2010 focused on the evidence available to support the assumption that increasing the role of non-physician clinicians would improve health care effectiveness and efficiency. The review asked, "What is the impact of professional role revision on quality of care and outcomes"? When looking at the evidence available on PA role revision, the review concluded that the majority of studies, which were conducted in the United States, "often lack a clear description of the number of patients, physician assistants and physicians, the qualification of the physician assistants, and a precise account of the tasks and responsibilities of the professionals involved in a patient's care....The available evidence is largely based on non-experimental studies and narrative analysis of the data."⁵¹

⁴⁸ Ibid.

⁴⁹ Bonnie Sibbald & Martin Roland, "Understanding controlled trials: Why are randomized controlled trials important?" (1998) *BMJ*, 316:201, <http://www.bmj.com/content/316/7126/201><http://www.bmj.com/content/316/7126/201>

⁵⁰ See Volume 2 for details on the literature review.

⁵¹ Ibid.

Available Canadian data are often based on the CF-trained PA experience. Canadian Forces PAs are very highly trained and the prerequisites for the military PA program are rigorous: each requirement involves high benchmarks and achievement-oriented credentials⁵². Canadian Forces PAs:

- must be a member of the Canadian Forces
- must have 12-15 years of service
- must be merit-listed for promotion to Warrant Officer
- must possess a Level 6 Medical Technician qualification, at the rank of Sergeant, and have successfully completed the Junior Leadership Course or Professional Level
- may access a graded entry system, which is based on prior learning, for candidates with advanced standing or experience, such as other allied health professionals or paramedics

Military PAs also practise in a milieu that has layers of supervision, professional and ethical codes and a unique culture. Comparisons between CF-trained PAs and civilian PAs, based on both background and practice, should therefore be made with caution.

HPRAC reviewed the draft evaluation report of the demonstration projects, the *Ontario Physician Assistant Implementation—Report of the Evaluation Subcommittee*. The quantitative data presented in the report were limited (i.e., “Much of the evaluation data in this report is qualitative, derived from interview, surveys, and focus groups. As such, this data reflects the perceptions of the respondents. There were limited sources of concrete, quantitative measures of the impacts of the PAs in the demonstration sites for some of the evaluation dimensions.⁵³”) and did not always show expected results, such as a reduction in acute care lengths of stay⁵⁴.

The data did, however, measure some positive impacts of the PA role, such as reduced wait times for emergency department patients.⁵⁵ In addition, one of the evaluative dimensions addressed “the ability for clients/patients/staff to not be harmed by an accident or mistakes when receiving or providing care.”⁵⁶ Interviews with supervising physicians provided the data for this dimension. Survey findings indicated a positive impact on patient safety and the quality of patient outcomes; however, there was no direct patient safety measurement tool available to quantify this impact. See Chapter IV, “PA Initiatives in Ontario” for more information on the demonstration projects.

In its application for regulation under the RHPA, the applicant noted that little research relevant to health care in Ontario was available to support its application, but felt that U.S.-based research could be used in its place, since “the data and lessons are likely to be relevant to the Canadian setting given that many things in health care transcend national boundaries.”⁵⁷ HPRAC has, however, weighed the many and significant differences between the Ontario and U.S. health care systems (e.g., health care frameworks and delivery; political, decision-making and legal systems;

⁵² CAPA, “PA Education Programs,” www.capa-acam.ca/pa-students/pa-education-programs.

⁵³ *Ontario Physician Assistant Implementation: Report of the Evaluation Subcommittee* (draft), p. 2.

⁵⁴ *Ibid.*, p. 22.

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*, p. 33.

⁵⁷ CAPA, *The Canadian Association of Physician Assistants’ Application for Regulation of the Physician Assistant Profession in Ontario* (January 2012), p. 4.

the role of personal insurance coverage; possible differences between academic preparation and prerequisites for PA studies; supply issues; respective political/social contexts; etc.), and supports a more cautious interpretation of the data. In determining whether the applicant had met the risk of harm threshold, therefore, HPRAC carefully considered the quality and quantity of relevant, verifiable evidence.

Newness of the PA Profession

The applicant also noted that the newness of the PA profession in Canada may play a role in the scarcity of relevant research.⁵⁸ The PA role in Ontario was announced quite recently—in 2006—and its first class graduated in 2010. By the end of 2012, a total of 101 PAs are expected to have graduated from PA educational programs in Ontario,⁵⁹ and it is believed that educational programs will continue to graduate PAs at the same rate in the years to come. The profession within Ontario is, therefore, small and new. This fact was noted in many consultation submissions and has also been a recurring theme in HPRAC’s risk of harm discussions. Because of this “small/newness” factor, the lack of complaints data (see Chapter IV, “Additional CPSO Enquiry”) was not interpreted as reflecting a low level of associated risk.

There are many related positive aspects to the current reality of the PA profession in Ontario. The profession’s newness can be expected to provide a layer of risk mitigation, for example, albeit a time-limited one. Few PAs are currently practising in Ontario, and the introduction of a PA to health care settings and the associated revision of practices, procedures, guidelines, directives and other policies should contribute to a heightened scrutiny of the practice, as with the introduction of any new profession. As well, PAs are in the public eye—and aware of the increased scrutiny. Theoretically, the very small number of practising PAs may provide opportunities for “hand-picking” applicants and for the easier identification of risky practices. As PAs enter the workplace in greater numbers, and as more patients and health care providers are exposed to the concept and practice of the physician assistant, the mitigation of risk is expected to decrease. Currently, there are over 25,000 physicians⁶⁰ and over 126,000 nurses⁶¹ providing quality health care to Ontarians. Since there are approximately 110 practising PAs in Ontario right now,⁶² few patients will be exposed to the practice until the profession grows. By extension, this also means that few patients in Ontario will be exposed to any risk involved in the practice of the PA profession. Consultation comments have noted that there is no evidence to indicate that patient safety is currently not adequately managed.

⁵⁸ Ibid.

⁵⁹ HealthForceOntario, *Ontario’s Physician Assistant Initiative*, <http://www.healthforceontario.ca/Work/OutsideOntario/HealthProfessionalsOutsideOntario/OntarioPhysicianAssistantInitiative.aspx>

⁶⁰ Ontario Physician Human Resources Data Centre, “Physicians in Ontario by Specialty of Practice and Local Health Integration Networks,” (2011), <https://www.ophrdc.org/Public/Report.aspx>

⁶¹ College of Nurses of Ontario, “Membership Highlights 2011,” http://www.cno.org/Global/docs/general/43069_stats/43069_MembershipStatistics2011-Highlights.pdf

⁶² Jeff Goodyear, “Ontario’s Physician Assistant Initiative,” HPRAC Briefing regarding PA regulation: (March 2012).

Importance of the Supervisory Relationship

In considering the evidence, HPRAC reflected on the term “risk of harm.” This term, according to HPRAC’s primary criterion,⁶³ refers to situations in which a substantial risk of physical or mental harm may result from the practice of a profession. Because all PAs in Ontario work under the supervision of doctors, risk of harm is mitigated to a large extent by the supervising physician.

For example, in this province, controlled acts may only be performed by certain health care professionals, including physicians.⁶⁴ In some situations, however, these acts may be delegated to others through medical directives. The establishment of specific medical directives that permit each PA to perform certain controlled acts within specified parameters is a prerequisite to PA practice. CAPA’s application for regulation describes the close working relationship between PAs and supervising physicians related to delegation of controlled acts: “Every act performed is by agreement with the physician. Every act performed is one delegated by the physician....The PA’s supervising physician(s) will delegate a controlled act(s) based on the determination of the PA’s competencies....When activities are delegated both the PA and physician must be able to demonstrate that the delegation is appropriate in the circumstance and that the PA can competently perform the delegated tasks...”

CPSO’s policy on medical directives notes that, “In all instances where a controlled act is delegated, the act remains the responsibility of the physician who authorized it.”⁶⁵ Thus, although a PA might carry out potentially high-risk activities, the supervising physician is responsible for a PA’s performance of those procedures. Regulation would not change this delegation model and the applicant did not propose a change to the delegation model.

Although some PAs will likely practise more autonomously than others, the profession is structured such that a PA will always require supervision by a physician. The applicant notes that PAs “practice medicine within a formalized physician/PA relationship. PAs supplement, not supplant, the work of physicians as both a philosophy of the profession, and reality of clinical practice.”⁶⁶

The level of supervision provided by a physician is known in the literature as “negotiated autonomy”⁶⁷; it can vary considerably from PA to PA and depends on the jurisdiction, practice setting, experience, training, competence, employers’ requirements and trust relationship between the physician and the PA. The mutable physician–PA trust relationship, as well as variable and changeable PA competencies, affects the everyday delegation of activities to the PA. Where PAs have greater autonomy, greater trust between the physician and the PA is required. Where there is a greater degree of risk to the patient, it is assumed that the physician will be less likely to delegate, and that the PA will therefore practise with less autonomy and/or

⁶³ See Volume 2.

⁶⁴ See Chapter VI: Other Considerations, for more information on controlled acts.

⁶⁵ CPSO, *Delegation of Controlled Acts Policy #8-10* (2004, updated 2010), <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1554>.

⁶⁶ CAPA application (see Appendix C), p. 4.

⁶⁷ Mittman et al.

that supervision levels will be adjusted accordingly. Overall, the unique PA–physician relationship presents challenges in understanding, on a profession-wide level and within individual health care settings, which tasks performed by individual PAs are subject to which accountability levels.

HPRAC’s literature review has shown that, within the United States, the required frequency of direct contact with a physician varies from daily (in most states), to weekly (in 12 states), to 30-day intervals (in seven states); in three states, physicians are required to review only 10–15% of the PA’s charts, or to direct PAs in areas of complex specialty, such as surgery.⁶⁸ The applicant has noted that, “In carrying out potentially high risk activities, the level of risk will determine the physician and PA’s ability to be progressively more remote from one another while the tasks are being performed.”⁶⁹

Secondary Criteria: Public Interest

In order for HPRAC to consider the secondary criteria, the applicant must first demonstrate, with evidence, that there is a risk of harm. The purpose of the secondary criteria is to measure the appropriateness of regulation under the RHPA for professions that HPRAC has determined pose a risk of harm to the public. The risk of harm threshold was not met for the application regarding physician assistants in Ontario. As a result, any discussion of the secondary criteria has not been included in this report.

Chapter Summary

Notwithstanding the potential value of mid-level practitioners, such as PAs, in increasing a physician’s productivity, HPRAC’s criteria and process examined the evidence regarding whether the applicant meets the risk of harm threshold and whether it is otherwise in the public interest that the profession be regulated under the RHPA. HPRAC’s review process does not include an assessment of the merit of the profession seeking regulation. The evidence submitted by CAPA has not met the risk of harm threshold. Additionally, because physicians supervise PAs’ performance of their duties, and because the profession is small (and, as a result, most patients are not exposed to a PA’s care) and new in Ontario (and therefore PAs are operating under a greater degree of scrutiny), the application did not show that, at this time, the practice of the PA profession poses a substantive risk of harm to the health and safety of the people of Ontario. An assessment of the secondary criteria was not included in this report.

⁶⁸ R. Cooper and S. Stoflet, “Diversity and consistency: The challenge of maintaining quality in a multidisciplinary workforce.” *Journal of Health Services Research and Policy*, 9 (Suppl. 1), 39-47(2004).

⁶⁹ CAPA application (see Appendix C), p. 11.

Chapter VI: Other Considerations

As discussed in Chapter V, the application for PA regulation under the RHPA was assessed according to HPRAC's criteria and process, and does not currently meet the risk of harm threshold. HPRAC reflected on the minister's referral and considered other information in developing its recommendation.

The Regulatory Landscape

The RHPA is based on a controlled acts model that assumes that some health care procedures have a more significant risk of harm than other procedures. The RHPA lists 13 procedures⁷⁰ that, if not performed correctly and by a competent practitioner, have a high element of risk. These procedures are known as controlled acts, and the model identifies the existence of risk in a particular act.

The regulation of health professionals under the RHPA is just one part of a system of regulation. The RHPA is an overarching regulatory framework for risk mitigation and provides support for other aspects of the system such as effective governance (on both a micro and macro level), the ethical health care practitioner and the informed member of the public.

Currently, health professional regulation is not standardized in Canada. It ranges from completely autonomous self-regulation to direct government control, with some jurisdictions adhering to a self-administration model. The characteristics of regulation vary from province to province, and take into account both regional differences and the distinct character and evolution of different health care professions. Thus, the term “self-regulation” is understood differently in each province. Some provinces, for example, consider the ability to discipline members through peer review or to set standards of practice or entry-to-practice requirements to be essential components of self-regulation. Others have determined that a regulator with a governance body that primarily comprises members of the profession is the major determinant of self-regulating status.

In developing this recommendation, HPRAC reflected on guidance from other jurisdictions, such as the U.K., which highlights the importance of the wider regulatory landscape—including the structure of the profession and existing governance/regulatory arrangements in assessing the applicability of regulatory options—to ensure that a recommended regulatory intervention would add value and avoid unnecessary duplication in protecting the public. HPRAC also reflected on the range of ways (with different costs and effectiveness) of introducing regulation and controls, and focused on which alternatives and regulatory regimes could be appropriate and proportionate models for the PA profession. As well, HPRAC looked at the concerns of health professional colleagues, which were provided through HPRAC's consultation program, about statutory regulation of the profession.

⁷⁰ *Regulated Health Professions Act, 1991* (RHPA), s. 27(2).

Some of HPRAC's deliberations on the regulation of PAs have also been noted by the U.K.'s Department of Health in a publication on health professional regulation.⁷¹ The report identifies the dimensions of risk that can be used to inform decisions on its management:

- Whether the act is carried out by a professional on their own, or as part of a supervised team who can support, guide and scrutinize practice;
- Whether the act is carried out by a professional who is part of a well managed organization that has in place managerial assurance systems to protect patients and the public;
- Whether the act is carried out by a professional who has a stable employment pattern, where any problems might be identified over time, or whether it is carried out by a more mobile short tenure practitioner working in a variety of locations, whose practice is less likely to receive consistent oversight;
- The quality of education and training of the practitioner carrying out the act;
- The experience of the practitioner carrying out the act; and,
- Whether there are systems in place to ensure that the practitioner is regularly and effectively appraised and developed to ensure that they are up to date with current practice.

HPRAC reviewed the application to better understand the model of regulation that was being proposed. The applicant suggested that "CPSO be the regulating body for the PA profession in Ontario." The applicant did not provide relevant details about how this might be accomplished, however; e.g., should PAs be regulated as a class of CPSO membership or by some other means? Would regulation of Ontario PAs resemble regulation of PAs in another jurisdiction? How would PAs interface with CPSO's regulatory functions?

A Registry of Practitioners

HPRAC considered the concepts described above, the size of the PA profession (now and in the near- and mid-term), the unique physician–PA supervisory relationship and the absence of strong evidence of risk of harm (see Chapter V: Rationale). HPRAC also considered the feasibility, applicability, potential benefits and risks of a range of regulatory options. The impact that different regulatory interventions (other than statutory regulation) would have on the residual risk related to the PA profession was also discussed at length. HPRAC recognized the potential cascade effects of giving the public and other health care professionals' assurance about the qualifications and training of individual PAs as an additional and necessary step in establishing the profession in Ontario; and ensuring quality care especially in interprofessional settings. Finally, HPRAC considered which option would be commensurate with future statutory regulation, should evidence that meets the risk of harm threshold become available.

⁷¹ Department of Health (United Kingdom), Extending Professional Regulation Working Group, *Extending Professional and Occupational Regulation: the Report of the Working Group on Extending Professional Regulation* (2009), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102824.

The best “fit” for the health care system in Ontario is a registry model, an approach that is currently used in some jurisdictions instead of full statutory regulation. In the absence of sufficient evidence regarding risk of harm, a compulsory PA registry will strengthen the health care delivery framework in Ontario by confirming, for the public and other health care team members, the training and qualifications of every practising PA in Ontario.

HPRAC’s position was confirmed by various consultation program comments, including those of CPSO. That submission suggested that a compulsory registry would be more appropriate for PAs, due to physician supervision and because of the small size of the profession in Ontario. The organization believes that a registry could be made compulsory through CPSO policies that would specify that its members could only work with PAs who are listed on the registry.⁷²

Registries in Other Jurisdictions

In addition to its three major reviews (literature, jurisdiction and jurisprudence; see Chapter IV: What We Learned), HPRAC looked at the registration of PAs in other jurisdictions, and learned that PAs are not well established or routinely regulated outside the United States. To determine best practices in overseeing PAs, therefore, HPRAC looked more closely at the features of the Alberta and U.K. PA registries, as well as at registries used for unregulated health care workers in British Columbia and Ontario.

At a minimum, a registry can be a professional information repository for practitioners of an unregulated health profession, and can help the profession organize and facilitate data management. Participation in a registry is usually voluntary, so members of an occupational group who practise the profession but do not participate in the registry operate outside the reach of the registry holder.⁷³ Several features were identified, however, that provide an additional level of assurance and oversight. For example, some registries mandate participation by making it a condition of employment, especially at publicly funded facilities.⁷⁴ Other registries, upon registration, require participants to subscribe to the same “fitness to practice”⁷⁵ standard and code of conduct.

Registry Models

Building on the above-noted information as well as the model proposed by CPSO in its consultation comments,⁷⁶ and with the goal of enhancing accountability and oversight, HPRAC

⁷² HPRAC, *Stakeholder Feedback on the Regulation of Physician Assistants under the Regulated Health Professions Act, 1991 (RHPA): Responses from Organizations*.

⁷³ The registry’s holder would be responsible for maintaining the registry.

⁷⁴ BC Care Aide & Community Health Worker Registry, FAQ, <http://www.cachwr.bc.ca/FAQ.asp?NavPage=15&Ticket=>.

⁷⁵ “Fitness to practice” has been defined by the College of Nurses of Ontario as a physical, mental condition or disorder that may affect a health professional’s ability to practise. See <http://www.cno.org/what-is-cno/councils-and-committees/committee/fitness-to-practise-committee>.

⁷⁶ HPRAC, *Stakeholder Feedback on the Regulation of Physician Assistants under the Regulation Health Professions Act, 1991 (RHPA), Responses from Organizations*, pp. 84-96.

examined possible registry models for PAs in Ontario. At a conceptual level, regulatory oversight can exist along a continuum and the design of a registry can include any number of features. Some options for registries are more complex, relating to differences in relative levels of accountability and oversight; HPRAC's proposed models reflect the trend towards increasing oversight. A common feature of all three models is the ability of employers and supervising physicians to know that a PA listed on the registry has met all entry-to-practice requirements in the province. The three models are outlined below.

Status Quo

PAs in Ontario currently have the option to obtain certification through an independent council of CAPA, the Physician Assistant Certification Council of Canada (PACCC). The voluntary nature of certification means that PAs in Ontario are currently able to practise without complying with certification requirements. Features of certification include:

- the requirement for PAs to complete an accredited educational program, as well as successful completion of the national exam;
- the requirement for completion of continuing professional development (CPD) credits; and
- a removal mechanism for members who fail to meet CPD requirements.

HPRAC has developed three mandatory registry models that strengthen this existing practice, provide additional oversight to the PA profession and provide assurance that all PAs in Ontario have met common entry-to-practice requirements, and fulfill their continuing education requirements.

Model 1 (Simple)

With this model, the requirements for registering on the registry are aligned with processes that currently exist for certified PAs. Enhancements would include:

- compulsory participation for employment in Ontario;
- a criminal records check;
- the attestation of adherence to a code of conduct (which could either be CAPA's existing Code of Ethics or a new code created by both CAPA and the registry holder); and
- a removal mechanism for participants with a criminal conviction.

Model 2 (Enhanced)

For illustrative purposes, and in order to showcase the range of features that may be included in a registry, consideration could be given to elements that show increasing oversight.

Implementation would be based on cost-benefit and implementation viability. A registry could include the features described in Model 1 as well as further enhancements, including:

- a complaints function managed by the registry holder. Dismissal reports from employers would be submitted to the registry owner when the PA has breached the profession's code of conduct.
- the requirement for employers to report any PA violations of the code of conduct; and

- consent-based information, which would be made available to potential employers.

Model 3 (Complex)

This model would include the features described in Model 2 as well as further enhancements, including:

- a complaints function managed by the registry holder. The complaints function could range in complexity, and include procedural fairness for PAs; and
- additional removal mechanisms specific to the complaint.

Preferred Model

HPRAC weighed the risk of harm considerations, the newness and current size of the profession, and PAs' close relationship with a supervising physician against the complexity involved in the different registry models. HPRAC also considered the benefits of mandating participation in a registry that provides more “muscle” than regular registries. HPRAC believes that Model 1 (simple) is more appropriate for the PA profession in Ontario at this time. More complex features could be added as the profession matures.

Although these registry models have been presented as a continuum, it is not assumed that PA profession would progress from models 1 through 3. It may be appropriate to stay at a particular level for the foreseeable future. It may also be appropriate to move from any of the three models directly to statutory regulation, if supported by evidence.

Registry Governance

Because of the newness and size of the profession, Ontario PAs do not have provincial professional association representation. CAPA is a nationally based organization; according to its website, its mission is to “foster development of the Physician/Physician Assistant Model to ensure quality care for Canadians; and improve access to that quality medical care.”⁷⁷ CAPA advocates for the profession across the country and has provided evidence that it has succeeded in gaining its membership's support. For example, it states in the application that there are roughly 300 PAs practising in Canada, that CAPA has about 400 members, that 140 delegates attended the CAPA Annual Conference; and that 99 members attended the Annual Members Meeting.⁷⁸ CAPA's membership appears to strongly support its association.

CAPA currently manages a registry of PAs. CAPA is also a professional association that, like all such organizations, is mandated to protect the professional interests of its profession. If a new PA registry is intended to assure the public that it is solely concerned with protecting the public interest, its management “should be moved outside of the professional association sphere.

⁷⁷ CAPA, Mission and Vision, (2012), <http://capa-acam.ca/about-capa/mission-and-vision>.

⁷⁸ CAPA application (see Appendix C), p. 23.

To help it understand the question of registry ownership, HPRAC looked at the holders of PA registries in other jurisdictions. For example, the registry for U.K. PAs is held by the UK Association of Physician Assistants, which is not a regulatory body, and does not have an equivalent in Ontario; in Alberta, however, the PA registry is managed by the College of Physicians and Surgeons of Alberta.

During the consultation program, CPSO supported a compulsory registry and offered its stewardship in maintaining the registry. In considering this idea, HPRAC looked at the physician–PA supervisory relationship, which is central to the PA profession, as well as CPSO’s experience and resources as a regulator of health professionals and its ability to provide support to the PA profession as it integrates into Ontario’s health care system. HPRAC also took into account the greater degree of confidence afforded Ontarians under this model, because PA registry requirements would be aligned with CPSO policies that regulate its members’ practice with employing PAs.

For these reasons, HPRAC recommends that CPSO manage a compulsory PA registry.

Interprofessional Collaboration

Interprofessional collaboration (IPC) is central to the efficient delivery of care in Ontario’s health care system. Although there are varying definitions of the terms “interprofessional care” and “interprofessional collaboration,” HPRAC accepts HealthForceOntario’s definition for interprofessional care: “the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to delivery quality care within and across settings.”⁷⁹

In recent years, HPRAC has examined the concept of IPC and its impact on Ontario’s health care system. In 2007, the Minister of Health and Long-Term Care asked HPRAC to recommend mechanisms that facilitate and support IPC amongst health colleges, beginning with the development of standards of practice and professional practice guidelines where regulated professions share the same or similar controlled acts. In 2008 and 2009, HPRAC delivered two interim reports⁸⁰ and a final report,⁸¹ respectively, to the minister.

Previous HPRAC reports have recommended regulatory reform as the key way to enhance collaboration among some health professions. The policy recommendations were meant to have wider applicability to health care providers, regardless of their regulatory status. As a result, the recommendations were used as a reference when HPRAC considered collaboration between PAs and other health professions in Ontario.

⁷⁹ HealthForceOntario, Interprofessional Care Steering Committee, *Interprofessional Care: A Blueprint for Action in Ontario*, <http://www.healthforceontario.ca/upload/en/whatishfo/ipc%20blueprint%20final.pdf>.

⁸⁰ HPRAC, *An Interim Report to the Minister of Health and Long-Term care on Mechanisms to Facilitate and Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals* (March 2008), www.hprac.org/en/reports/archivedreports.asp.

⁸¹ HPRAC, *Critical Links: Transforming and Supporting Patient Care. A Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration and a New Framework for the Prescribing and Use of Drugs by Non-Physician Regulated Health Professions* (January 2009), www.hprac.org/en/reports/.../HPRACCriticalLinksEnglishJan_09.pdf.

The application described the close relationship between PAs and physicians but provided limited evidence about other members of the interprofessional team. In addition, HPRAC's literature review found few articles that contained details about collaborative relationships involving PAs, and found that the most common form of collaboration is between a PA and a single supervising physician, or a small group practice. Consultation comments noted that the variability in PAs' competencies based on the structure of the profession may confuse other members of the IPC team.

HPRAC also learned that there are efforts underway to facilitate collaboration between PAs and other professions. For example, through Ontario's PA initiatives, PAs are already working successfully as part of interprofessional teams in various health care settings in the province. Recent evidence from the demonstration projects indicates that "among administrators, health care team members, [supervising physicians] and PAs, there [is] widespread support for continued implementation of the PA role in Ontario."⁸² CAPA also reported that it has developed a consultative relationship with CPSO and the broader physician community. Examples of multidisciplinary teams including PAs were identified in the literature and key informants described the successful operation of PAs in an interprofessional, military environment.

HPRAC recognizes that the up-take of IPC principles requires the buy-in and participation of all stakeholders as well as a significant cultural change. Ontario's healthcare landscape is still becoming familiar with IPC, both conceptually and in practice. In order to be most constructive to the PA community at this time, HPRAC has focused only on the most relevant IPC enablers from previous reports.

Interprofessional care teams may find it challenging to work together seamlessly when the roles, responsibilities and competencies of team members are not clearly defined. Some initial ways to help clarify the PA role, therefore, might include promoting information sharing between a PA champion and Ontario's regulatory health colleges beyond the physician community through an official partnership with CPSO. As supervising physicians and PAs work together to enhance patient care, a PA champion and CPSO could mutually benefit from identifying joint efforts to provide education about a PA's authority under the supervisory model of care. PAs could also benefit from the experience and guidance of CPSO in seeking opportunities to participate in IPC discussions with other regulatory colleges. As a priority, relationships should be developed with the health professions that share elements of the PA scope of practice.

The RHPA promotes flexibility and IPC within the health care system by allowing regulated health professions to share elements of their scopes of practice. In Ontario, a PA's scope of practice mirrors that of their supervising physician. Additionally, PAs may have overlapping scopes of practice with a number of health professions and may perform some of the same controlled acts. At times, IPC teams may be challenged because of medical directives that are not clear and well understood by all members of their teams. For example, legislation permits a physician to delegate a controlled act, or provide an order to perform a procedure that is not a controlled act, to a PA or other member of an IPC team. A PA, however, cannot delegate an

⁸² *Ontario Physician Assistant Implementation: Report of the Evaluation Subcommittee* (draft), p. 35.

order to perform a controlled act to another member of the IPC team and, in hospitals and long-term care homes, a PA may not be able to authorize orders to other team members to perform other clinical activities.

Interprofessional care could be enhanced in the following ways:

- At the practice level, there are opportunities for the supervising physician to facilitate communication among team members. IPC team members who better understand the role and responsibilities of PAs will be better able to deliver excellent care.
- Delegation orders need to clearly address and be well understood by all members of IPC teams. Well-crafted medical directives are critical in addressing confusion amongst members of IPC teams, and enabling the function and participation of PAs on IPC teams.
- In addition to the medical directive, individual IPC teams could develop plans and protocols that promote cooperation, working to full competencies and an understanding of medical directives; this will also enable the delivery of care.⁸³ Tangential benefits include the opportunity to “group problem-solve” best procedures for delivering care while integrating the new PA role into the team.

To facilitate collaboration between PAs and other health providers, the public and IPC team members also need assurance that a given PA is qualified and able to provide high-quality care. This could be accomplished by enabling a compulsory PA registry, which will continue the organizing efforts of the profession as well as instill confidence in PAs, by ensuring that all PAs have met the same entry to practice standards, and that they participate in continued professional development activities.

Delegation and Medical Directives

Some characteristics of the PA profession will challenge the usual approach to health professions. For example, individual physician–PA “trust relationships” will vary across the profession and from practice to practice. These relationships are critical to the physician’s delegation of duties to the PA, and to the PA working to the extent of his or her ability and scope of practice. Different practice settings will have different requirements and thus a wide degree of variability in physician–PA work agreements is to be expected.

As noted by the applicant, the potential for risk of harm related to the delegation of controlled acts and other clinical activities may increase as a PA’s physical separation from the supervising physician increases⁸⁴:

As physical separation becomes more apparent, the patient is left more dependent upon the PA and therefore more reliant on the judgment and decision making process of the PA. As this autonomy increases, there is a greater need to have an articulated statement of what the PA can do and how it will be carried out. In the case of assisting in surgery, the surgeon

⁸³ Federation of Health Regulatory Colleges, *An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario*, <http://mdguide.regulatedhealthprofessions.on.ca/why/default.asp>.

⁸⁴ CAPA application (see Appendix C), p. 11.

gives direction and if something is amiss, corrects it on the spot; therefore little is needed in the context of documentation. When the PA is without direct supervision on the ward or in a clinic it becomes important that everyone understands the PA's and the physician's roles and responsibilities and that an accountability mechanism has been built into this type of autonomous practice.

Potential for risk of harm may also increase as oversight levels from the supervising physician decrease. The jurisprudence review identified a U.S. case, *Macdonald v. United States of America*, in which a physician was found liable for failing to properly supervise a PA. The judge issued an opinion stating that, "In this case the oversight required by the standard of care was missing. A random review of approximately 10% of all patients treated by the clinic is not sufficient. Such a review allows the physician's assistant to substitute his judgment for that of a doctor's."⁸⁵ Although Canadian courts have found American legal principles to be informative, they are not bound to follow American precedent or legal principles.

It is not clear whether medical directives⁸⁶ are currently comprehensive enough to manage highly autonomous PAs. Regardless of the level of supervision, however, it is the physician who determines which controlled acts are delegated to the PA, outlines the parameters of the PA practice and agrees to the particular supervisory structure—and it is therefore the physician who assesses and is responsible for the risk level.

Although the unique supervisory relationship is a solidly protective mechanism, CPSO has outlined some concerns about potential and harmful PA activities that may not be fully addressed by medical directives and/or its delegation policy. Currently, for example, PAs cannot be removed from practice and remediation cannot be ensured for issues related to "professionalism," which is defined by CPSO as including "communication problems or...sexual abuse of patients."⁸⁷ (Certified PAs in Ontario can be removed from the registry for failing to complete professional development activities,⁸⁸ and non-certified PAs are not tracked by the registry.)

HPRAC also heard that there is the need for appropriate administrative follow-up for PAs who have been terminated for misconduct.⁸⁹ In its consultation submission, the OMA also noted that, "Currently, there is no formal recourse to deal with a physician assistant who is practicing in an unprofessional, incompetent or dangerous manner. In the event of a patient complaint, the

⁸⁵ As reported in HealthCare Providers Insurance Exchange, *Physician Liability for Non-Physician Clinicians*, (2008–11), p. 9, <http://www.hpix-ins.com/pdf/Expired-Modules/Physician-Liability-for-Non-Physician-Clinicians.pdf>.

⁸⁶ According to the Federation of Health Regulatory Colleges of Ontario, medical directives are indirect physician orders, used to expedite patient care by competent health professionals. See <http://mdguide.regulatedhealthprofessions.on.ca/why/default.asp>.

⁸⁷ HPRAC, *Stakeholder Feedback on the Regulation of Physician Assistants under the Regulation Health Professions Act, 1991 (RHPA), Responses from Organizations* (2), p. 87.

⁸⁸ Physician Assistant Certification Council of Canada, *Continuing Professional Development Policy* (May 3, 2012), <http://capa-acam.ca/wp-content/uploads/2012/06/PACCC-CPD-Policy-FINAL-3-May-2012.pdf>.

⁸⁹ HPRAC, *Stakeholder Feedback on the Regulation of Physician Assistants under the Regulation Health Professions Act, 1991 (RHPA), Responses from Organizations*, p. 40.

complaint is lodged against the supervising physician.”⁹⁰ The OMA also raised a concern about the potential lack of consistency on the part of employers vis-à-vis confirming a PA’s certification or work history during the hiring process.⁹¹

HPRAC considered the professionalism-related risks that exist for the patients of practising PAs. In trying to quantify these risks, HPRAC reviewed its previous work on the regulation of personal support workers (PSW), which detailed existing labour laws that govern employment practices. In this 2006 report, shortcomings in the Ontario Labour Relations Act (OLRA) and the arbitration process were highlighted, as was employers’ duty to develop policies for their employees, as a way to prevent abuse.⁹²

HPRAC also identified various mechanisms to address harm, such as enhanced supervision and the application of diligent employment standards.⁹³ These existing elements, coupled with the responsibility of the supervising physician to oversee the clinical acts of the PA, mitigates, to a great extent, the risk related to the practice of PAs that is not covered by the current delegation policy.

For regulated health professions, the appropriate avenues to address professionalism issues and administrative follow-up are legislation and regulations. CPSO has noted that “the absence of a direct route to regulatory intervention does not mean that no action is available: the avenues of criminal or civil action would remain open and direct, of course, and would offer a more immediate connection between the wrong, if any, and accountability of the PA.”⁹⁴

Delegation⁹⁵ by physicians is a good way to ensure the delivery of safe care. CPSO is currently revising its delegation policy and has noted in its consultation submission that an opportunity exists to revise its delegation policy to address supervising and delegating to PAs, along with addressing the practice of PAs through various other oversight tools.⁹⁶ CPSO also noted that the features of statutory regulation that best address professionalism-related issues (i.e., quality assurance and a complaints mechanism) can be tangentially applied to PAs through existing and related programs that apply to CPSO members.⁹⁷ Considering the lack of relevant evidence regarding risk of harm and the size and newness of the profession, the primacy of the supervisory relationship (and, by extension, CPSO policies and guidelines) is a clear way to manage residual risk.

⁹⁰ Ibid., p. 38

⁹¹ Ibid.

⁹² HPRAC, *The Regulation of Personal Support Workers* (September 2006), p. 12, <http://www.hprac.org/en/reports/resources/PSW-FinalReportSept27-06.pdf>.

⁹³ Ibid., p. 13.

⁹⁴ HPRAC, *Stakeholder Feedback on the Regulation of Physician Assistants under the Regulated Health Professions Act, 1991 (RHPA), Responses from Organizations*, p. 92.

⁹⁵ According to the Federation of Health Regulatory Colleges of Ontario, delegation “refers to the delegation of controlled acts in accordance with the provisions in the *Regulated Health Professions Act* (RHPA).” See <http://mdguide.regulatedhealthprofessions.on.ca/why/default.asp>.

⁹⁶ HPRAC, *Stakeholder Feedback on the Regulation of Physician Assistants under the Regulated Health Professions Act (1991), Responses from Organizations* (2), p. 93.

⁹⁷ Ibid.

Because CPSO is reviewing its delegation policy at the same time as it is involved in introducing the PA profession into Ontario, an opportunity exists to address PA-specific delegation issues within a revised delegation policy as well as in companion-piece guidelines. As well, a library of applicable CPSO policy documents and guidelines should be revised or drafted; these materials could provide much-needed guidance on the physician–PA supervisory relationship. Properly prepared and overseen individual agreements between PAs and supervising physicians are also critical in addressing residual risk. Other aspects of risk are expected to be addressed over time as the profession matures.

In addition (although it does not directly address professionalism issues), a compulsory registry would provide a central information repository and a way to track all practising PAs.

Is a Registry an Appropriate Regulatory Mechanism?

For quality assurance purposes, HPRAC assessed important features of effective regulatory regimes against outcomes of the enhanced registry; see Table 2 for details of this assessment.

Table 2. Effectiveness of Proposed Registry

Principle of Effective Regulatory Regime	Registry Outcomes
Ensures that the professional has the necessary skills to practise the profession	Practising PAs have an accredited education and training, complete a national exam, and attend professional development courses
Identifies and addresses any problems that arise	Supervisory relationship will identify and address any clinical problems that arise. Supervisory relationship and mandatory reporting will identify other problems.
Enables patients as well as employers to determine which practitioners are qualified	Registry may be public. Mandatory nature of the registry will ensure title protection within Ontario.
Removes from practice any health care professionals who do not meet agreed upon standards	Ability to remove a professional from registry on certain grounds.

Chapter Summary

In formulating its recommendation, HPRAC considered the regulatory landscape as well as the size of the PA profession, the unique physician–PA supervisory relationship and the absence of strong evidence of risk of harm. HPRAC also recognized the cascade effects of reassuring the public about the qualifications and training of individual PAs. At this time, HPRAC recommends the creation of a simple, compulsory registry—managed by CPSO—that will strengthen the

health care delivery framework in Ontario. More complex features could be added as the profession matures.

Delegation agreements are key to the supervision of PAs as well as the proper functioning of interprofessional teams. CPSO is reviewing its delegation policy at the same time as it is involved in introducing the PA profession into Ontario, and an opportunity exists to address PA-specific delegation issues within a revised delegation policy and associated guidelines. There is a shared need for CPSO guidance (by PAs, doctors, IPC team members and the public) on the physician–PA supervisory relationship. Properly prepared and overseen individual agreements between PAs and supervising physicians are also critical in addressing residual risk. Other aspects of risk are expected to be addressed over time, as the profession matures.

Chapter VII: Conclusion

Safe, effective and patient-centered health care is the primary goal of regulatory oversight. Regulatory regimes must promote these goals, clearly and simply, for both health care practitioners and patients. Ultimately, regulatory oversight should be proportionate to risk. Professional regulation under the RHPA is a significant part of the regulatory framework for the delivery of health care, but it is not the only way to effectively protect the public.

HPRAC carried out its published process in assessing the application for regulation of the PA profession in Ontario.⁹⁸ This process included an extensive consultation program; consideration of the evidence provided by the applicant; literature, jurisdictional and jurisprudence reviews; and conducting more detailed research in several key areas. HPRAC noted the lack of relevant available research about the risk of harm aspects of the PA profession, and that the newness and small size of the PA profession in Ontario and in other non-U.S. jurisdictions are likely contributing factors to the lack of relevant Canadian evidence. Consultation comments noted similar factors.

HPRAC also considered the nature of the profession's supervisory structure. Although PAs have access to most controlled acts and may engage in potentially high-risk procedures, supervising physicians are responsible for PAs' performance of those procedures. The unique PA–physician relationship significantly mitigates the risk inherent in the practice of the PA profession,

HPRAC's review process did not include an assessment of the merits of the profession seeking regulation. The value to the health care system associated with the PA practice is not the focus of HPRAC's risk of harm questions. Rather, HPRAC's criteria and process examine whether the applicant meets the risk of harm threshold and whether it is otherwise in the public interest that the profession be regulated under the RHPA.

The outcome of the HPRAC assessment process is that the applicant did not pass the risk of harm threshold: there is insufficient evidence to require regulation under the RHPA as a means of managing residual risk. Public safety and quality of care are sufficiently upheld at this time through the delegation model and a regulatory registry. Because regulatory oversight can exist along a continuum, HPRAC proposes that the PA profession in Ontario build on the existing certification process in the form of a mandatory registry, which will increase certainty about practitioners' qualifications. A registry that strengthens the existing process would also be a way to provide additional oversight to the PA profession as well as give assurance that all PAs in Ontario have met common entry-to-practice requirements and that they participate in continuing education. This model will support the ongoing practice of PAs as part of interprofessional teams.

HPRAC also supports CPSO in its efforts to revise its delegation policy, and encourages CPSO to develop clear, comprehensive policy and guidelines for supervisory doctors that addresses both clinical and non-clinical issues identified in a PA's practice.

⁹⁸ See Volume 2 for HPRAC's Criteria and Process document.

Appendix A: About HPRAC

HPRAC was established under the *Regulated Health Professions Act, 1991* (RHPA) with a statutory duty to advise the Minister of Health and Long-Term Care on matters related to the regulation of health professions in Ontario. This duty includes providing advice to the minister on:

- whether unregulated health professions should be regulated;
- whether regulated health professions should no longer be regulated;
- amendments to the RHPA;
- amendments to a health profession's Act or a regulation under any of those Acts;
- matters concerning the quality assurance programs and patient relations programs undertaken by health colleges; and
- any matter the minister refers to HPRAC relating to the regulation of the health professions.

The minister relies on recommendations from HPRAC as a key source of evidence-informed advice when formulating policy vis-à-vis health professions' regulation in Ontario. In providing its advice and preparing its recommendations, HPRAC is independent of the Minister of Health and Long-Term Care, the Ministry of Health and Long-Term Care (MOHLTC), the regulated health colleges, regulated health professional and provider associations, and stakeholders that have an interest in issues on which it provides advice. This ensures that HPRAC is free from constraining alliances and conflict of interest and that it is able to carry out its activities in a fair and unbiased manner.

HPRAC presents its recommendations in a report to the minister for consideration.

Recommendations are advisory only and the minister is not bound to accept HPRAC's advice. The report is confidential, although the minister may choose to publicly release an HPRAC report. Any follow-up action is at the discretion of the minister. Should the minister choose to accept HPRAC's advice, MOHLTC is responsible for implementation based on the direction of the government.

In developing its advice to the minister, HPRAC strives to ensure that its processes are thorough, timely and efficient, and built on a foundation of fairness, transparency and evidence-based decision-making. HPRAC undertakes research to provide the evidence for its conclusions, drawing on organizations and individuals with relevant expertise, both in Ontario and elsewhere, and adjusts its consultation process for each profession it considers.

Appendix B: Physician Assistant Consultation Program

HPRAC's Consultation Approach

When a referral is received from the minister, HPRAC determines relevant public interest concerns and questions and tries to understand all perspectives on an issue, including those of key health professionals, other affected health professionals, clients, patients, advocates and regulators. Each issue proceeds through a multi-stage process in which information and responses are requested from and shared with stakeholders. HPRAC also conducts literature, jurisdictional and jurisprudence reviews, and engages in key informant interviews. Its analysis of the issues helps HPRAC determine whether additional information is required, and the appropriate processes to be used.

HPRAC used two mechanisms to obtain broad stakeholder input into this referral process:

1. Written submissions through an online survey, and
2. A feedback form that could be submitted via fax or by mail.

Overview of the Consultation Process

Stakeholder input informs HPRAC when developing its recommendations to the minister. As noted above, as part of its consultation process, HPRAC notifies and consults with stakeholders whom HPRAC believes could potentially be affected by its recommendations. Stakeholders and interested parties include regulatory health colleges, health profession associations, health care providers and the public. In general, the following key principles are used to develop the consultation program:

- The inclusion of interested stakeholders and members of the public at a level of involvement that reflects their needs and interests.
- The flexibility to respond to unanticipated issues and stakeholder input throughout the referral period.
- An expectation that the consultation process will crystallize broad themes as well as highlight unanticipated “outlier” issues. The data are not expected to indicate support for, or opposition to, a particular topic. By definition, respondents self-select to participate in the consultation process and, in so doing, present their own particular views on the subject matter.
- The incorporation of issues, concerns, comments and perspectives into the recommendation-making process.
- Ensuring that all consultation material is available in both official languages (on request, HPRAC will provide information on accessible formats).

Within its mandate, HPRAC may consult with selected individuals and organizations if it needs additional information to complete the review of the minister's referral. Persons or organizations with identified expertise or a stake in the issue may be invited, at HPRAC's discretion, to make presentations, reports or submissions. These individuals and groups may include hard-to-reach groups as well as those who may not have the resources to participate in standard processes and methods. (See Table 1 for a list of organizations consulted for this referral.)

Risk of Harm

The risk of harm concept is fundamental to the protection of the public and thus this principle is woven into the fabric of RHPA. Section 30 (1) notes that risk of harm is a "serious bodily harm [which] may result from the treatment or advice or from an omission..."

The Supreme Court of Canada, in the leading case concerning the interpretation of the phrase, defined "serious bodily harm" as "any hurt or injury, whether physical or psychological, that interferes in a substantial way with the physical or psychological integrity, health or well-being of a complainant."⁹⁹

For this referral, HPRAC followed the following approach¹⁰⁰ to risk of harm in its evaluation of whether the physician assistant profession should be regulated, either independently or in conjunction with an existing profession under the RHPA:

The term risk of harm refers to actions where a substantial risk of physical or mental harm may result from the practice of the profession. This criterion is intended to provide a clear articulation of the degree of harm posed by the profession to the health and safety of the public. In addressing the risk of harm in this context, the applicant is asked to identify the risks associated with the practice of the profession concerned, as distinct from risks inherent in the area of health care within which the profession operates.

Public Interest

Again, as part of the RHPA, public interest is stated within the minister's duty to ensure "that appropriate standards of practice are developed and maintained and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board."¹⁰¹

Within the context of this definition, HPRAC used the following principles to evaluate whether the profession of physician assistants ought to be regulated under RHPA:

- Protect the public from unqualified, incompetent and unfit health care providers, to the fullest extent possible.

⁹⁹ *R.v. McCraw*, [1991] 3 S.C.R. 72.

¹⁰⁰ HPRAC, *Regulation of a New Health Profession under the Regulated Health Professions Act (RHPA) 1991: Criteria and Process*,

http://hprac.org/en/projects/resources/RegulatingaNewProfession_CriteriaProcess_Nov2011.pdf.

¹⁰¹ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, s. 3.

- Establish mechanisms to encourage the provision of high-quality care.
- Provide the public with freedom of choice within a range of safe health care options.
- Establish a scope of evolution in the roles played by individual professions and flexibility in how individual professionals can be utilized, to ensure maximum system efficiency.
- Ensure that regulation is proportionate to risk to patients and the public.
- Ensure that regulation is efficient, by minimizing duplication and avoiding delays in taking action to protect the public.

Table 1. Physician Assistants Referral: Stakeholders

Type	Organization Name
Regulatory college	College of Audiologists & Speech-Language Pathologists of Ontario
	College of Chiropodists of Ontario
	College of Chiropractors of Ontario
	College of Dental Hygienists of Ontario
	College of Dental Technologists of Ontario
	College of Denturists of Ontario
	College of Dietitians of Ontario
	College of Massage Therapists of Ontario
	College of Medical Laboratory Technologists of Ontario
	College of Medical Radiation Technologists of Ontario
	College of Midwives of Ontario
	College of Nurses of Ontario
	College of Occupational Therapists of Ontario
	College of Opticians of Ontario
	College of Optometrists of Ontario
	College of Physicians and Surgeons of Ontario
	College of Physiotherapists of Ontario
	College of Psychologists of Ontario
	College of Respiratory Therapists of Ontario
	Ontario College of Pharmacists
	Royal College of Dental Surgeons of Ontario
	Transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario
	Transitional Council of the College of Homeopaths of Ontario

Type	Organization Name
Regulated professional association	Transitional Council of the College of Kinesiologists of Ontario
	Transitional Council of the College of Naturopathy of Ontario
	Transitional Council of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario
	Board of Directors of Drugless Therapy - Naturopathy
	Association of Dental Technologists of Ontario
	Association of Ontario Midwives
	Denturists Association of Ontario
	Dietitians of Canada
	Nurse Practitioners' Association of Ontario
	Ontario Association of Medical Laboratories
	Ontario Association of Medical Radiation Technologists
	Ontario Association of Naturopathic Doctors
	Ontario Association of Optometrists
	Ontario Association of Psychological Associates
	Ontario Association of Speech-Language Pathologists and Audiologists
	Ontario Chiropractic Association
	Ontario Dental Association
	Ontario Dental Hygienists' Association
	Ontario Medical Association
	Ontario Nurses' Association
	Ontario Opticians Association
	Ontario Pharmacists' Association
	Ontario Physiotherapy Association
	Ontario Podiatric Medical Association
	Ontario Psychiatric Association
	Ontario Psychological Association
	Ontario Society of Medical Technologists
	Ontario Society of Occupational Therapists

Type	Organization Name
	Ontario Society of Chiropractors
	Registered Massage Therapists' Association of Ontario
	Registered Nurses' Association of Ontario
	Registered Practical Nurses Association of Ontario
	Respiratory Therapy Society of Ontario
Professional Association	Canadian Association of Physician Assistants
Organization/Group	National Physician Assisting Examination Board (NPAEB)
Organization/Group	Ontario Hospital Association
Organization/Group	Canadian Medical Association
Hospital CEOs	All hospital CEOs in Ontario
Educational Institutions	All health and medical faculties of Ontario universities
PA Education Program	McMaster University
PA Education Programs	The Consortium of PA Education (University of Toronto, Northern Ontario School of Medicine and The Michener Institute for Applied Health Sciences)
PA Education Programs	Manitoba's Physician Assistant Education Program
Academic/Expert	Rod Hooker

Type	Organization Name
Local health integration network (LHIN)	Central
	Central East
	Central West
	Champlain
	Erie St. Clair
	Hamilton Niagara Haldimand Brant
	Mississauga Halton
	North Simcoe Muskoka
	North East
	North West
	South East
	South West
	Toronto Central
	Waterloo Wellington

Consultation Questionnaire

1. In your view, does the applicant meet the “risk of harm” threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?
2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?
3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.
4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.
5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members’ commitment and ability to support the costs and development of statutory regulation.

6. From your perspective, does the applicant convincingly demonstrate the extent of the impact by which the regulation of Physician Assistants will have on Ontario's wider health system? You may wish to comment on such issues as inter-professional collaboration, labour mobility, access to care, health human resource productivity and health outcomes.

7. Do you have any other general comments?

Appendix C: CAPA Physician Assistant Application (January 2012)



Health Professions Regulatory Advisory Council Application

January 2012

Canadian Association of Physician Assistants

www.capa-acam.ca



Health Professions Regulatory Advisory Council

Application

January 2012

The Canadian Association of Physician Assistants'
Application for Regulation of the
Physician Assistant Profession in Ontario

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The Canadian Association of Physician Assistants' Application for Regulation of the Physician Assistant Profession in Ontario

Introduction

The Canadian Association of Physician Assistants (CAPA) is pleased to have this opportunity to respond to the questions raised by The Health Professions Regulatory Advisory Council (HPRAC) in its application form.

On behalf of the membership it is CAPA's desire that the Physician Assistant (PA) profession be regulated in Ontario. It is the Association's belief that regulation of this profession would offer considerable benefits to the Ontario health care system. It would also ensure that there is a system in place which would emphasize patient safety, accountability for actions and enhance the quality of care for Ontarians. This will be demonstrated throughout this application. Specific examples are provided which will reinforce the above mentioned statement.

Canada's Physician Assistants (PAs) are academically prepared and highly skilled health care professionals educated in the medical model that practice medicine under the supervision of a licensed physician within a patient-centered health care team. PAs possess a defined body of knowledge including clinical and procedural skills, and a professional philosophy to support effective patient care. PAs apply these competencies to collect data and interpret information, develop and further investigate differential diagnoses, make appropriate clinical decisions, and carry out required diagnostic, procedural, and therapeutic interventions. They practice medicine within a formalized physician/PA relationship. PAs supplement, not supplant, the work of physicians as both a philosophy of the profession, and reality of clinical practice.

In Canada the PA is a newly introduced health care professional within the public health care system. They have existed in the Canadian Forces Military for over 50 years. PAs were introduced into the public health care system 10 years ago in Manitoba. In Ontario the profession only burgeoned with the Demonstration Projects, which commenced in 2006. The Demonstration Project initiative was aimed at introducing PAs to a number of different health care settings through a series of demonstration projects across the province of Ontario. PAs have been enthusiastically received by the physicians with whom they work and by the institutions in which they serve. At first, physicians and other health care professionals were unfamiliar with the PA role and were understandably cautious at the commencement of the Demonstration Projects. With time, careful introduction, and good performance, almost all of this has evaporated. PAs employed in Ontario are well accepted into the team by their professional colleagues. This has been evidenced by interviews with PAs and by the recent research by Kulatunga-Moruzi (2011).¹

However, the infancy of this profession in Canada presents a challenge in providing the appropriate response to HPRAC, considering the dearth of published literature on practitioners in Ontario and Canada. On the other hand, PAs have practiced widely in the United States (US) for decades with over 83,000 practicing PAs in the US currently.² (AAPA, 2011) This has resulted in a significant body of work, which is referenced in the literature reviews conducted by the Secretariat of HPRAC under the headings of *Literature*, *Jurisdictional* and *Jurisprudence Reviews*. Based on the quality of the studies and the credibility of the sources, CAPA believes that these reviews may be relied upon and that lessons may be drawn from this literature. In most circumstances the data and lessons are likely to be relevant to the Canadian setting given that many things in health care transcend national boundaries.

¹Kulatunga-Moruzi, C. (2011) *The integration of the inaugural graduates of the McMaster University Physician Assistant Education Program into Ontario's health care system: a survey of employer perceptions and reflections*. PhD dissertation, Department of Family Medicine, Faculty of Health Sciences, McMaster University, Hamilton, ON.

²The American Academy of Physician Assistants. (2011). Vital Statistics p. 1. Retrieved from: http://www.aapa.org/uploadedFiles/content/News_and_Publications/For_the_Media/VitalStats_Factsheet_Update_final.pdf

In fact, CAPA has been unable to find an error with the analysis in the reviews. This could present an issue in responding to HPRAC, considering that in many circumstances it is CAPA's recommendation for the reader to consult the *Literature, Jurisdictional* and *Jurisprudence Reviews*. As a result, CAPA has chosen only to confirm the review where the questions clearly demand it and to focus on reports by our own practitioners.

To ensure that this brief captures the Canadian experience, and in particular the Ontario experience, numerous individual interviews have been carried out with practicing PAs and their supervising physician(s). Furthermore, this brief has been reviewed in detail by a reference group of practicing PAs to ensure alignment with present practice realities. This brief will draw heavily on the various inputs.

Flux and Opportunity

A first and overarching observation about the practice of PAs in Ontario is that the practice is evolving and changing rapidly. PAs have been employed for almost four years with the exception of new PA graduates. It is safe to say that there are very few types of practices that are fully developed. Already PAs are finding their scope of practice is expanding as the physician/PA relationship develops and knowledge of the particular practice grows.

All other regulated health professions were well established prior to the passing of the Regulated Health Professions Act (RHPA). In this case regulation can have a very positive role in establishing the attributes of safe practice and help to shape the profession in a way that will produce the most positive environment for everyone involved, in particular, the patient. It is with this in mind that CAPA embraces the regulatory process so that safe, cost effective, and integrated practice can be delivered to the patients of Ontario as the profession develops to its full potential.

Primary Criterion: Risk of Harm

To attempt a general description of services performed by PAs would be difficult. PAs are trained as generalists. PAs engage in a broad range of controlled acts which varies from specialty to specialty. Their scope of practice mirrors that of the supervising physician(s); therefore the nature of services provided are entirely dependent on the practice of the physician(s) with whom the PA is associated. .

The Literature Review describes very different practices for PAs and this is also true in Ontario. For example: the practice of an orthopaedic surgeon is very different from that of a physician practicing in a long-term care setting, which is again very different from practice in an emergency department. Beyond saying that each of those physicians treat patients, it would be difficult to give a general description of the service provided by these three kinds of physicians. Likewise, the practice of each of the PAs associated with these physicians is radically different from the other. Therefore, this brief will describe the present practices of several PAs here in Ontario with the goal of providing a complete description of potentially risky services under the section addressing controlled acts. The information included in the case studies below is anecdotal and was gathered from interviews conducted with individual PAs currently practicing in Ontario.

To properly understand the PA practice we must appreciate the fundamental relationship between the PA and the physician. Every PA works with and values the close working relationship with a supervising physician(s). Interviews with physicians disclose that they too value the close working relationship with PAs. Every act performed is by agreement with the physician. Every act performed is one delegated by the physician and one which the physician is competent to perform him or herself. Depending upon the setting and the type of patient, the PA might report immediately to the physician. On the other hand, once protocols are established and there is a level of trust, comfort and mutual knowledge between the PA and the physician, the level of supervision may change in such a way that the physician may, for example, be presented with a patient's case at a later time. Whether or not the following descriptions describe this close relationship adequately in each case, it nevertheless is true in every case.

Case Studies in Ontario

Case 1:

In an emergency department, the PA reviews the history of the patient, examines the patient and orders tests as required. This includes: blood tests, X-rays, or an ultrasound. After this work-up, the PA may make a diagnosis and write a prescription for treatment which could include medications. This may or may not be countersigned by the supervising physician(s), depending on the internal hospital procedures. If the patient is critically ill, the PA may begin arranging for transfer to another service or to another institution even before the supervising physician(s) has been able to see the patient. PAs are targeting certain patient populations that require urgent assessment in volume overloaded departments to initiate treatment. For example, elderly patients arriving via Emergency Medical Services complaining of hip pain after a fall are flagged and a PA assesses the patient, administers analgesia and orders X-rays. Once the diagnosis of hip fracture is confirmed, orthopaedic consultation is initiated and a bed order is arranged to expedite care. PAs are improving safety and quality operations in the emergency department by completing the patient follow ups including blood and urine cultures and final radiological reports. This ensures quality care for patients and allows the physician to continue to maintain the flow of the department.

Case 2:

In a medical unit at a large hospital, a PA is responsible for a group of patients whose critical care medical issues have been addressed, are stable and are awaiting transfer. The attending physicians change every two weeks and are present in the ward usually once a day. The PA monitors the original admitting condition and takes action to continue care or adjust as needed. The PA acts as a liaison to all other services in order to get the patient transferred and arranges outpatient services. If the patient develops certain kinds of problems, under agreement between the physician and PA, the PA makes the diagnosis, does the necessary tests, and prescribes therapy which is most likely initiated prior to the arrival of the attending physician. The PA can also discharge patients according to the agreement.

Case 3:

In a trauma centre a PA works with an orthopaedic surgeon. For in-patients the PA provides the continuum of care for all the patients' health needs while they are on the orthopaedic service. The PA is starting to become first call for orthopaedic response in the trauma centre. The PA frequently attends to trauma cases without the surgeon, if for example he or she is in the operating room. The PA becomes a member of the trauma team, taking responsibility for the orthopaedic part of the trauma care. An open fracture is a critical trauma and the PA may irrigate and cleanse the fracture in a timely fashion. The surgeon attends upon the call of the PA. Under a list established by mutual agreement between the PA and the surgeon, the PA can order ECGs, blood tests, blood transfusions, X-rays, CT scans and MRIs.

Case 4:

In a long-term care unit the PA receives all patients and is responsible for the admission, history as well as the physical examination, and sets up the initial orders. The PA is accountable for looking after the continuing and emergent health care needs as well as keeping the supervising physician(s) informed. In this particular case, the advent of the PA has made it possible for the supervising physician(s) to focus on more complex cases while sharing the remaining workload.

Case 5:

In the busy practice of an orthopaedic surgeon, a PA has been hired. This is not part of the demonstration project and no hospital or other institution is involved. The PA sees patients only when the surgeon is present in the office. The PA sees both new and returning patients, some being seen for very complex care. The PA is seeing most of the new patients presenting with chronic pain. After completing the patient work-up, reviewing tests sent by the referring physician and/or those previously ordered from the practice, the PA then writes up a plan of care including any and all further tests and medications. In every case, the PA presents this information to the orthopaedic surgeon who also sees the patient. The orthopaedic surgeon then countersigns all requisitions for tests and prescriptions.

This has allowed some relief in an overburdened practice and is lessening wait times for referred and returning patients. This case represents a new model for Ontario and appears to be one in which there is rapidly growing interest.

The above listed case studies clearly demonstrate the role differences amongst PAs and how their tasks can vary in speciality and setting. The tasks they perform will depend on the environment in which they function and their supervising physician's capabilities.

Diagnostic Modalities

In the descriptions above, a wide variety of modalities have been described as being employed by PAs. Once again, this differs entirely with the setting and the medical directives agreed to between the PA and the physician(s), as well as with the length of time the relationship has been established. It became clear in speaking with PAs that as the knowledge of each other's practices developed, the modalities used by PAs under mutual agreement were expanded time and time again. Some diagnostic modalities will be described in more detail in the controlled acts section but

generally speaking PAs will make a diagnosis by employing a history of the illness and conducting a physical examination which could include: blood and urine tests, X-rays, ultrasound, or other imaging modalities.

Exclusivity of Practice

No activities are exclusively performed by a PA. As stated earlier the PAs scope of practice mirrors that of his/her supervising physician(s). PAs are only permitted to undertake tasks which their supervising physician(s) is competent to perform. There is some overlap with regards to scope of practice among PAs, nurse practitioners, midwives and psychologist. However, the PA role is very specific in that all acts are delegated by the supervising physician(s) in accordance with the PAs capabilities and the physician's scope of practice. CAPA cannot speak on behalf of other unregulated health professionals.

Complaints and Discipline

Due to the recent introduction of this profession into the public health care system in Canada, CAPA is unable to provide a 10 year history, or any history for that matter, regarding the rate and nature of complaints in Ontario. To CAPA's knowledge there has not been any disciplinary or investigative process by any association or similar organization. In fact the only avenue of address for potential problems has been through the supervising physician(s) and/or the employer's corporate process where it exists. In these cases only anecdotal accounts are available.

The *Jurisprudence Review* completed by the Secretariat of HPRAC focuses mostly on malpractice claims and shows the history in the US. There is little reason to think it will differ here, except that the incidence of malpractice suits is much less in Canada.

Public Safety and Regulation

At the core of safety for the patient is the sufficiency of the physician/PA relationship with clearly understood mutual responsibilities, appropriately delegated activities, and proper supervision by the physician(s). When activities are delegated, both the PA and physician must be able to demonstrate that the delegation is appropriate in the circumstance and that the PA can competently perform the delegated tasks. The supervision must be by a method appropriate to the activities being delegated. Any independent third party, be it a patient, a fellow practitioner, an administrator, or a regulator, must be able to know and understand how this supervision occurs and why it is appropriate. With this, the PA and physician are mutually responsible to each other and even dependent upon one another.

Central to the successful, safe introduction and expansion of this profession to the province is a method of ensuring that these mutual responsibilities are not only understood, but acted upon. The first group of physicians in the demonstration project all became better informed about PAs as a result of being part of the project. We can expect however, that PA practices will now begin to roll out with physicians who are not similarly inducted. If people do not understand their responsibilities they cannot be expected to carry them out and patient safety will be at risk. Even in the demonstration project, and with all the best of intentions, this problem has already occurred.

This is best illustrated by a case from the demonstration project.

Case 6:

Knowing little about PAs, however, learning about the role from the information posted prior to the Ontario Demonstration Project, a physician became interested about working with a PA in his setting. After all necessary procedures and the passing of time, an experienced US trained PA was hired. The physician now reflects ruefully upon the beginning, and

states candidly that the problems upon introduction were his and not those of the PA. Despite the fact that this physician had become one of the more informed physicians on the subject in Ontario, he did not truly understand the training of PAs, nor the need to specifically work with and educate a PA into a particular practice setting. He understood the responsibility of the PA to him, but he did not understand his responsibility to the PA. As a result he placed the PA in a position where the PA was expected to do things for which he was not prepared for. He failed to appropriately delegate activities and he failed to adequately supervise. He now knows that the responsibility is mutual and necessary.

This led to problems with patient care, as well as significant concerns and negative feedback from other staff and administration. He is frank that their concerns were legitimate. Almost two and a half years later he understands his role and enjoys the relationship and intense mutual responsibility that has developed with the PA. The PA now also has the respect of other staff and administration.

This case illustrates how the public can be put at risk when the developing team, even with the best of intentions and goodwill, can falter through insufficient guidance. In the *Jurisdictional Review* provided by the Secretariat of HPRAC, it is clear that a major focus of regulation among the different jurisdictions has been to ensure that physicians and PAs are not left to figure out how to 'make it work' and that a system exists which provides guidance to both the physician and PA. This will avoid potentially putting the patient at risk.

The *Jurisdictional Review*³ described Manitoba, North Dakota, California, and Minnesota as examples of jurisdictions which have developed and mandated procedures for the physician/PA team to follow, upon beginning to practice together. These steps, when completed, help ensure adequate preparation and supervision in order to protect patients. These models give guidance and can be used to formulate Ontario specific mandates. CAPA recommends that this development be one of the first tasks assigned to the new regulatory body and that the power to do so be granted to it, with approval from the Minister of Health if need be, through a mechanism deemed appropriate by the legislature.

There are other areas where lack of regulation may place patients at risk.

The *Jurisdictional Review* refers to a small group of the PA profession in the United States who engaged in inappropriate behaviour. Some practiced the profession incompetently; some practiced while they were impaired through illness or addiction, some attempted to practice outside of their appropriate scope while others engaged in sexual relations with their patients, or engaged in criminal activity and thereby displayed a lack of moral character necessary in a health profession. Fortunately, the cases reviewed represented a small percentage of PAs who engaged in this type of behaviour however, they do clearly demonstrate the risk that PAs can pose to the public through inappropriate behaviour.

Regulation prevents those who pose as PAs and possess inadequate training or supervision from holding themselves out as PAs and thereby deceiving patients. Having an independent regulatory body in place overseeing practicing PAs would provide an additional guarantee that registered PAs have met the established standard of care.

Regulation provides the public with a mechanism of redress. This may take the form of reprimand, mandated further training, probationary periods of practice, or even suspension of practice. On the other hand, regulators often deal with the ill practitioner in a manner which protects the public but helps with the rehabilitation or redirection of the practitioner.

³The Secretariat of Health Professions Regulatory Advisory Council (HPRAC). (2011). *Jurisdictional Review*. (pp.14-16) Retrieved from: http://www.hprac.org/en/projects/resources/JurisdictionalReview_RegulationofPhysicianAssistantsundertheRHPA.pdf

This is particularly important in the case of the practitioner addicted to drugs or alcohol. Once again, because PAs are human, at a very conservative estimate, 5 per cent of practitioners will have this problem.⁴(The Joint Commission, 2008) This is usually a catastrophe for the practitioner personally and sometimes for the patient. At the very least the public needs to be protected from the impaired practitioner given that the risk of problem increases with impairment.

A regulatory college has been shown to be a critical part of the treatment and recovery of practitioners.⁵(TheOMA, 2009)As the number of PAs grows in Ontario over the coming years, there will be a growing need to address this issue. It should be addressed for several reasons. First and foremost it should be addressed to protect patients from those who would practice while impaired. Second, it should seek to restore PAs to healthy practice so as to protect this valuable health care resource. Third, it offers the best chance to restore a professional to a healthy and fulfilling life, a worthy goal on compassionate grounds alone.

Liability Insurance

There are presently two types of coverage available to PAs which can ensure coverage in order to protect the needs of the patient in case of malpractice. The Hospital Insurance Reciprocal of Ontario (HIROC) provided coverage for the majority of PAs employed with the Ontario Demonstration Projects. The onus was on the employer in these instances to arrange for general and professional liability coverage for the PA. It may be that when PAs are the employee of a public hospital HIROC will also cover them in the future. For all other cases, CAPA has arranged liability insurance through Willis Canada Inc. PAs may purchase individual coverage through this service.

Professional Titles

In keeping with present practice in Ontario and elsewhere, the terms Canadian Certified Physician Assistant (CCPA), Physician Assistant Certified (PA-C) and Physician Assistant should be restricted to this professional group.

Referral

Given that a PA works with physicians, all referrals will be made after consultation with the physician. This will ensure appropriate referral.

Recent Advances

Recent and future advances in practice provide no particular threat given that each of these will first be introduced to the practice of medicine. With time and in the best interest of patient care, it will become clear which advances could be used by PAs. When delegation occurs, safety will be paramount in the consideration given that the process of delegation will follow the system for delegation established by the regulator.

⁴The Joint Commission Perspectives on Patient Safety. (2008). *Addressing substance abuse among health care professionals*. 8(11), 5-11

⁵The Ontario Medical Association (OMA). (2009). *Physician Health Program Annual Report*. Retrieved from: <http://php.oma.org/PDF%20files/2009PHPAnnualReport.pdf>

Secondary Criterion: Professional Autonomy

In discussing autonomy, CAPA recognizes that autonomy, delegation, and supervision are simply different ways of looking at a method of practice, with delegation and varying types of supervision resulting in different degrees of autonomy.

The first manner of supervision occurs when a physician and a PA jointly perform a task, for example, when a PA assists in surgery. Another example is when the PA and physician work together in an ICU or resuscitation room to insert a central venous line under ultrasound guidance. In this case one person controls the ultrasound machine to develop an image, while the other uses that image to insert the line.

A second type of supervision occurs when there is a line of sight of the activities. This occurs when a surgeon is inserting a flap, which has been elevated from the abdominal wall, into the head and neck during cancer surgery while the PA completes the closure of the abdominal donor site. It also occurs when a PA applies casting to a patient in one part of a plaster room while the surgeon is providing care to another fracture patient in the same plaster room.

A third type of supervision occurs when there is the ability to immediately intervene. This commonly happens in the emergency department, outpatient department or in office based practices. While the PA is seeing a patient the physician is in a different room, possibly even in a different unit, but is available immediately to intervene at the call of the PA either through voice or some electronic device.

The fourth type of supervision is through management and periodic review. This occurs when a PA works in a hospital, long-term care facility, or in an outpatient office and the physician is not always present. In these instances the PA carries out delegated activities based on medical directives developed with the supervising physician(s). Not only are these understandings in place, but there is an agreed upon process for the review of cases with the physician(s). It may be that the supervising physician(s) visits daily or weekly and reviews cases. As the *Jurisdictional Review* points out, in some cases there is a review of only a percentage of the charts of the patients seen. In all these cases the PA, when presented with problems that require physician consultation, would be able to ensure that the patient sees the physician in a timely manner for further assessment, either at the time of the physician's visit or by special visits.

It is apparent that in all these circumstances PAs are carrying out important, necessary, and potentially high risk activities. The level of risk will determine the physician and PA's ability to be progressively more remote, from one another, while the tasks are being performed. As physical separation becomes more apparent, the patient is left more dependent upon the PA and therefore more reliant on the judgment and decision making process of the PA. As this autonomy increases, there is a greater need to have an articulated statement of what the PA can do and how it will be carried out. In the case of assisting in surgery, the surgeon gives direction and if something is amiss, corrects it on the spot; therefore little is needed in the context of documentation. When the PA is without direct supervision on the ward or in a clinic it becomes important that everyone understands the PA's and the physician's roles and responsibilities and that an accountability mechanism has been built into this type of autonomous practice. Regulation with clearly stated methods and standards is the mechanism to guarantee the public that an accountability mechanism has been established.

Controlled Acts

PAs are currently performing many controlled acts delegated to them by the supervising physician(s). HPRAC desires to know which controlled acts are being performed under delegation now. Each controlled act will be reviewed with examples in many cases. For ease of reference, the following will use the number system, and an abbreviated description of controlled acts, as found in the RHPA Section 27(2).

1. Diagnosis

Every PA makes diagnoses in their practice setting. In some cases, such as an emergency department, the diagnosis is reviewed immediately. In other cases, such as a long-term care unit or an outpatient clinic, it may be reviewed later in the day or even days later.

2. Procedures below the dermis, etc.

PAs frequently perform procedures below the dermis depending upon the setting, for example; suturing lacerations in the emergency department, cleansing an open wound, assisting in surgery, and inserting lines.

3. Casting a fracture

Casting a fracture is performed in some orthopaedic and emergency department settings.

4. Spinal manipulation

Spinal manipulation is currently not performed by PAs; however, it is within the scope of practice for physicians and may be performed in the future.

5. Administering a substance by injection or inhalation

Frequently performed in a variety of settings.

6. Putting an instrument, hand or finger as per list I to VII

Frequently performed in most settings.

7. Forms of energy

PAs are now being trained to perform ultrasounds in the emergency department. In Ontario some PAs are trained for their use in the emergency department and certified to teach. These certified instructors, are teaching emergency physicians as well as other PAs.

X-rays, CAT scans, and MRIs are ordered by agreement with the physician and the radiology department in selected settings.

8. Prescribing drugs

All PAs prescribe. In some cases, because of a closed system such as a hospital pharmacy or the pharmacy of record for a long-term care institution, their prescriptions are honoured as written. Other settings require a physician's signature.

9. Vision and eye problems

Presently not performed as described in this section of the Act, however, since this is in the scope of practice for physicians it may be performed by PAs in the future.

10. Hearing aids

Not performed as described in this section of the Act.

11. Dental work

Not performed in non-military settings although Canadian Forces PAs are trained in and perform dental work while in the Forces.

12. Obstetrical care

This is currently practiced as described in this section of the Act.

13. Allergy challenge

This is in the scope of practice of physicians and although CAPA is unaware of PAs who have engaged in such activity, with training and supervision PAs may perform these in the future.

14. Psychotherapy

This is practiced in some selected settings as described in this section of the Act.

This list represents a great number of activities of critical importance to the patient. The public interest is served when patients can be assured that these important, and potentially risky tasks, are delegated appropriately.

Educational Requirements for Entry to Practice

In Ontario there are three university level physician assistant education programs which are accredited by the Canadian Medical Association (CMA) Conjoint Accreditation Services. The CMA Conjoint Accreditation Process provides the public with assurance that a health professional educational program has met national standards. PAs are trained as generalists and can be employed in a variety of clinical settings. They then have the ability to specialize in a particular area of medicine upon graduation. PAs can acquire the skills necessary through site specific training with the supervising physician(s) or through appropriate external sources and continuing professional development opportunities. The educational programs that are accredited are modeled after the CanMEDS Physician Competency Framework⁶ therefore the training which the PA receives mirrors that of a physician. The goal is to ensure that programs enable their students to acquire the knowledge, skills and attitudes to function as competent health practitioners for the benefit of all Canadians. The McMaster University Physician Assistants Education Program, Bachelor of Health Sciences Degree (Physician Assistant); the Canadian Forces Health Services Training Centre Physician Assistant Program, Physician Assistant Baccalaureate in an Allied Health Program; and The Consortium of Physician Assistant Education (which includes: the University of Toronto; The Northern Ontario School of Medicine and the Michener Institute for Applied Health Sciences) Bachelor of Science Physician Assistant Degree are accredited by the CMA Conjoint Accreditation Services. The University of Manitoba also offers a Master of Physician Assistant Studies program in Manitoba which is also accredited by the CMA Conjoint Accreditation Services.

In Appendix A the program descriptions for each of the academic institutions list the specific theoretical and clinical/practical experiences and describes the linkages between the education and training of each program and the diagnostic/assessment abilities, treatment modalities and services.

Number of Practitioners Educated in Ontario

CAPA does not have access to specific numbers regarding the percentage of practitioners who were educated in Ontario. Figures obtained from HealthForceOntario state that there are currently 65 PAs practicing in Ontario who were educated at the University of McMaster and the Consortium of Physician Assistant Education located in Ontario. In the Canadian Forces there are roughly 65 PAs practicing in Ontario who were educated at the Canadian Forces Health Services Training Centre located in Ontario. McMaster University has graduated 45 students from two classes and the Canadian Forces Health Services Training Centre has graduated 163 students from eight classes. The Consortium of Physician Assistant Education will have their first ever graduating class this June 2012. All 17 students have completed the program and most have obtained employment in Ontario. These students are scheduled to receive their diploma in June 2012.

There are 246 CCPAs in Canada, 210 have been educated and trained in Ontario. Since 1938, the CMA has played a leadership role in ensuring the national standard for the education of approximately 40,000 health care practitioners who perform diagnostic and therapeutic services to support physicians in the clinical setting. The CMA's Conjoint Accreditation Services model establishes a reliable measure of educational quality for health professions in

⁶Royal College of Physicians and Surgeons of Canada (RCPSC). (2005). *The CanMEDS Project Overview*. Retrieved from: <http://meds.queensu.ca/medicine/obgyn/pdf/CanMEDS.overview.pdf>

Canada.⁷(The Canadian Medical Association (CMA), 2010)Appendix A outlines the four educational programs' theoretical and clinical/practical experiences including how the professional body of knowledge and approach to diagnostic/treatment modalities and services apply with regard to these institutions.

It is important to note that the Canadian Forces Health Services Training Centre's program is only available to Canadian Forces members and personnel. PAs that are educated and trained under this program are employed across Canada within the Canadian Forces and upon discharge these PAs are employed in other health systems, in most jurisdictions within Canada.

Graduates from the different education programs with their CCPA designation are able to work in different jurisdictions within Canada. In Ontario PAs are for the most part working in the Canadian Forces as well as part of the Ministry of Health and Long-Term Care's (MOHLTC) Demonstration Projects and the Ontario PA Grant Program.

Association Membership Education Criteria

CAPA has six membership categories. For the purpose of this application reference will be made to the "Regular Member" category. Other membership categories referenced in the CAPA Bylaws include: Student, International Physician Assistant, Physician, Allied Health Care Professionals and Honourary Members. These members are not subject to the same educational criteria as a condition of membership as the Regular Member category. Regular Members, as defined by CAPA's Bylaws, have successfully completed a Physician Assistant Education Program recognized by the Physician Assistant Certification Council of Canada (PACCC), and will be employed in Canada or for a Canadian Agency. PACCC is an independent Council of CAPA that administers and maintains the PA certification process. A Regular Member shall be entitled to voice concerns and initiate discussions at Annual Members Meetings, to hold formal office, and to vote at membership meetings. Regular members will be entitled to all benefits and privileges of membership. Other membership categories are entitled to the privilege of the floor and to all the benefits and privileges of membership with the exception of the full right to vote. These membership categories shall only be entitled to vote on special resolutions regarding fundamental changes.

Employment in Ontario

In Ontario, employers typically require that an individual seeking employment as a Physician Assistant must have graduated from a CMA or Accreditation Review Commission on Education for the Physician Assistant, Inc. (ARC-PA) accredited program. ARC is the American equivalent to the CMA Conjoint Accreditation Services. The Demonstration Projects in Ontario also allow for selected International Medical Graduates and retired Canadian Forces PAs to be eligible for employment through this initiative.

⁷The Canadian Medical Association (CMA). 2010. *Working together for high-quality patient care section*, paragraph ¶ 1. Retrieved from: <http://www.cma.ca/learning/conjointaccreditation>

CAPA recommends that:

PA certification becomes the standard for employment in Ontario.

CAPA, through PACCC, administers and maintains the national PA certification process that includes a Physician Assistant Entry to Practice Certification Examination (PA Cert Exam) and a Continuing Professional Development (CPD) component in which members must obtain a required number of CPD credits within a specific time-frame to maintain their certification. PAs must have graduated from a CMA or ARC-PA accredited program to qualify to write the PA Cert Exam.

All persons wishing to obtain certification through the PACCC must be members of CAPA and must remain members of CAPA in order to track their CPD credits.

A formal relationship exists between the PACCC and the College of Family Physicians of Canada (CFPC) to provide online tracking options for CAPA's members. The CFPC has committed to enabling CAPA members to maintain their CPD using their password protected, 24/7 online tracking system. PACCC and the CFPC work closely to ensure that individual CAPA members obtain the necessary number of credits required for maintenance of certification. In the event that PAs are to become regulated it is PACCC's desire to work with the regulatory body to ensure that a proper process is implemented to maintain certification.

Regulations for Practice by a Regulatory Body

The requirements for registration with regulatory bodies, varies from province to province. PAs practicing in New Brunswick, Manitoba and Alberta must obtain a degree in Physician Assistant studies from a CMA accredited medical program. PAs practicing in the Canadian Forces are required to have successfully completed a degree from the Canadian Forces Health Services Training Centre, Physician Assistant Program. In Ontario PAs are not regulated and are employed in the Demonstration Projects or through the Ontario PA Graduate Grant Program. Specific conditions of practice for the jurisdictions of New Brunswick, Manitoba and Alberta are provided in Appendix C of this document.

CAPA recommends that:

There be one standard set of criteria for registering among the different regulatory bodies;

The regulatory bodies mandate that PAs graduate from a CMA or ARC-PA accredited program and successfully complete the PACCCPA Cert Exam.

Consistency among jurisdictions would facilitate labour mobility for PAs from one province to the other.

Body of Knowledge and Scope

A PA is a qualified health practitioner trained in the medical model and works with the supervision of a licensed physician in various health care settings. The PA's practice mirrors that of their supervising physician(s). After training the PAs scope will reflect that of the supervising physician(s) through additional training, education and supervision. Every qualified PA who has met the requirements for entry to practice has a core body of knowledge formed by the nationally accepted Scope of Practice and National Competency Profile.

It is important to note that PA educational programs offered in Canada are part of the Faculty of Medicine in their respective universities with the exception of the Canadian Forces (CF), which is part of the Health Services Division in the Department of Defence. These programs are reflective of the medical training provided for physicians by those faculties, but appropriately tailored for the PA profession. The wisdom of this approach is that PAs and physicians will both enter practice with a commonality of understanding and knowledge of the medical model of care.

PAs are taught in evidence-based teaching environments which emphasize critical analysis and evidence evaluation. PAs are required to evaluate changes in medical practice and make decisions that are appropriate for their clinical practice. This is achieved through the application of medical informatics and evidence-based medicine in partnership with the supervising physician(s). This is important given that evidence-based medicine forms the basis for the clinical practice of medicine in Canada. As physicians incorporate evidence based practice this becomes the standard by which the PA practices as well.

Continuing Professional Development

Participation in CPD is an attribute of healthcare professionals who place a high value in maintaining currency in their clinical field. CPD is also a requirement for PAs wishing to maintain their Canadian Certified Physician Assistant (CCPA) designation and currency in the clinical field.

The PACCC CPD committee policy requires that all CCPAs complete 250 CPD credits in a five year cycle in order to maintain their certification and CCPA designation. The CPD process for PAs has been modelled after the CFPC, which has a well-established history of managing CPD for their Canadian Family Physician members. The CFPC also provides assistance to PACCC by providing an online tracking system through their website to CAPA members who wish to track their CPD credits. The profession is supportive of CPD and views this as an important part of maintaining competency. CCPA designation is not only a way of ensuring that an entry-to-practice standard has been achieved but also a way of ensuring that CPD takes place amongst the profession.

CPD is divided into Mainpro-M1 and Mainpro-M2 credits. There is a third category, called Mainpro-C credits which are awarded for participation in CFPC-accredited programs that include a demonstrated self-reflective component.

PAs can earn Mainpro-M1 credits when they participate in structured learning programs, events or activities that focus on enhancing knowledge and skills integral to the practice of medicine. Mainpro-M2 credits are awarded primarily for self-directed, unstructured CPD or continuing medical education (CME) activities. Provided that the activity is relevant to the PAs practice as a physician assistant, it is likely to be Mainpro-M2 eligible. Mainpro-C credits are earned for activities that include a reflective component and promote strategies to incorporate acquired knowledge and skills into practice.

Controlled Acts

PAs are able to perform a wide range of controlled acts through delegation by their supervising physician(s). Although some of the controlled acts are performed by most or all of the profession, many are performed by only a small percentage of the profession, specific to their practice setting. Similar to physicians, PAs only perform controlled acts that their supervising physician(s) is qualified to perform. For example, all physicians have the potential to be qualified to perform acts related to obstetrical care, however, only those with advanced training demonstrating specific competencies are actually the physicians who perform these acts. The PA's supervising physician(s) will delegate a controlled act(s) based on a determination of the PA's competencies. When regulated, PAs will not require authorization to perform controlled acts under the RHPA, as they work under the delegation of those acts by physicians. This is in the patient's best interest since the patient is cared for by a skilled PA capably performing those acts as part of a team. The patient benefits because they will potentially have improved access to safe, quality care. Having the PA working with a supervising physician(s) in a collaborative team-based approach will enable the physician to share the caseload with his/her PA, thus allowing the physician to focus on more complex cases or even augment the number of patients seen. This is a more efficient model of care.

The controlled act of prescribing medication requires specific attention. Pharmacology and therapeutics are major components of the PA's education. A substantial portion of the clinical experience is dedicated to pharmacology. There is also a pharmacology component in the PACCC PA Cert Exam. The writing of a prescription by a PA, however, has been a challenging obstacle to the PA's ability to work to his/her full competencies and scope of practice, and a limiting factor to the patient receiving full benefit from the addition of the PA to the team.

In the hospital sector, medical directives are developed with the full knowledge and consent of the PA and supervising physician(s) and with the involvement of the hospital pharmacy. The pharmacist in this setting understands the medical directives, and is typically included during their establishment. This therefore results in the prescription, signed only by the PA, being honoured.

This also occurs in long-term care homes where there is a pharmacy of record with similar understandings and acceptance.

This process in Ontario becomes challenging when the PA is working in an out-patient clinic, hospital, or with a community based physician's practice and patients have their prescriptions filled at their local pharmacy. In these instances not all prescriptions written by PAs are honoured without question. Many local pharmacists are unaware of the role of a PA and therefore do not feel comfortable in releasing these prescriptions to patients without a physician's signature. This may result in delayed discharge from either a clinic or an institution while waiting for a physician signature.

Other jurisdictions have found that the limitations in the PAs prescribing authority have hindered PAs in being able to work to their full scope of practice. Many jurisdictions have developed a system to facilitate autonomous practice while recognizing it is never completely independent. Many jurisdictions in the US have developed systems, with formularies, training programs, and registration of PAs to facilitate this autonomy.⁸(The Secretariat of HPRAC, 2011)

⁸The Secretariat of the Health Professions Regulatory Advisory Council (HPRAC). (2011). *Jurisdictional Review*. (pp. 15-16) Retrieved from: http://www.hprac.org/en/projects/resources/JurisdictionalReview_RegulationofPhysicianAssistantsundertheRHPA.pdf

In the province of Manitoba, PAs are permitted to write prescriptions somewhat independently. Each prescription written by a PA must have the signature of the PA, the contact telephone number for the PA, and the name of the supervising physician(s).⁹(MPhA, 2006) This model of prescriptive authority should be further considered in the Ontario setting.

In almost all states within the US a system exists to authorize PA prescriptive privileges. Some of the systems reviewed in the US are reasonable in that they ensure patient safety, however, can be more administratively burdensome. CAPA believes the Manitoba model provides an excellent example for streamlined safe prescribing by PAs in Canada.

During the Ontario PA Symposium, December 5, 2011; CAPA was made aware that pharmacies in two separate communities in Ontario are in fact honouring the signatures of PAs for prescriptions. In these instances PAs are performing the controlled act of prescribing in accordance with our recommendations. This process was adopted in response to difficulty that patients were experiencing in obtaining their medication in a timely fashion.

CAPA recommends that:

Ontario should establish a process to allow the PA to write and sign a prescription that may be filled at any pharmacy, provided that this is within their medical directives as agreed upon with the supervising physician(s).

Pharmacists should be involved in the development of the process for PA prescribing. This process should include an education and awareness campaign to ensure that Ontario pharmacists are aware and understand the PA's competencies when working under the delegated authority of the supervising physician(s).

⁹The Manitoba Pharmaceutical Association (MPhA). (2006). *Clinical Assistant: Prescribing Authority, March Newsletter*, (pp. 7 – 8). Retrieved from: http://mpha.ca/pdf/MPhA_March2006_pg7pg8b.pdf

Economic Impact of Regulation

CAPA is uncertain of the costs associated with regulating the PA profession. From discussions with the College of Physicians and Surgeons of Ontario (CPSO), CAPA is aware that a substantial investment of time and resources is involved and that there are many systems that need to be established which will require funding and resources. To add another profession to the CPSO's portfolio would require supplementary funding.

Given the economies of scale and the extensive experience with regulation, CAPA feels that the CPSO would be in an ideal position to support this endeavour and that it would be less of a disruption to this organization than it would to a smaller less robust organization.

PAs, if regulated, would not only minimize risk to patients by ensuring practicing PAs are registered and licensed through the regulatory body but would also benefit hospitals and other health institutions by ensuring that PAs employed at their facility are from a regulated profession. Additionally, regulation of the profession would minimize the costs to these institutions in that these facilities would not have to spend the resources required to investigate the PAs educational process and be in a position of granting a de facto certification themselves as a facility.

CAPA is uncertain regarding the potential costs that may be incurred by potential employers when employing PAs.

PAs will be required to comply with regulatory requirements and this may, from time to time, take them away from providing patient care. This is necessary in order to protect the public interest and ensure safety to patients. PAs may be required to pay membership fees to the regulating body out of pocket; however, in certain circumstance PAs may be able to receive reimbursement from their respective employers. All regulated health care professionals are required to pay membership fees to their regulatory body and because membership is often a condition of employment they are frequently reimbursed.

Regulatory Mechanism

Currently the PA profession is not subject to any regulatory mechanism in Ontario. CAPA supports the regulation of PAs in Ontario. Once regulated, PAs practicing in the province will continue to work under the supervision of Ontario physicians. Given the close interwoven relationship between physicians and PAs, CAPA recommends and supports the regulation of PAs under the CPSO. As a voluntary professional association representing its members' interests, CAPA provides an advocacy and communications function on their behalf. CAPA, as a national association, believes that it would be a conflict of interest to become the provincial PA regulatory body while still providing an advocacy role.

Recommended Regulatory Mechanism

In Manitoba and New Brunswick the PA profession is regulated by the provincial colleges of physicians and surgeons. Similar governing bodies for physicians regulate the PA profession in most US states as described in the *Jurisdictional Review*. As a requirement for practice, PAs employed in Manitoba and New Brunswick must be registered with the respective provincial college of physicians and surgeons. PAs must also receive a license from the regulating body in order to practice within their jurisdiction.

CAPA recommends that:

The CPSO be the regulating body for the PA profession in Ontario.

CAPA believes that the CPSO would be an ideal fit for regulation of the PA profession under the RHPA. Based on preliminary discussions, between CAPA and the CPSO, the CPSO is exploring the regulation of PAs under the college.

CAPA recommends that:

The MOHLTC provide transitional funding to the CPSO so that the cost of PA regulation does not become a burden to physician members.

This would be similar to the support the MOHLTC provided to the midwifery college during its transitional days.¹⁰(The College of Midwives of Ontario, 2011)

¹⁰The College of Midwives of Ontario. (2011). History of the College section: *January 1993* ¶ 11. Retrieved from: <http://www.cmo.on.ca/history.php>

Conditions of Regulation

CAPA believes that certification through the PACCC should be a requirement for PA's entry to practice in Ontario.

CAPA recommends that:

Certification by the successful completion of the PACCC PA Cert Exam becomes a mandatory requirement for practice/licensure.

The regulatory bodies mandate that PAs graduate from a CMA or ARC-PA accredited program and successfully complete the PACCC PA Cert Exam.

PACCC is the body responsible for administering and maintaining the PA Cert Exam for PAs in Canada. PACCC develops and administers the PA Cert Exam, providing the CCPA designation upon successful completion of the PA Cert Exam and overseeing that CCPAs obtain 250 CPD credits in a five year timeframe in order to maintain the CCPA designation.

PACCC is prepared to continue to provide this role for PAs in Ontario as well as throughout Canada.

The Scope of Practice and National Competency Profile (NCP) was created with the support of The Royal College of Physicians and Surgeons of Canada (RCPSC) and the CFPC as a resource for PA's, supervising physicians, educators, legislators and other health professionals. The NCP has been adopted as the national standard of practice in Canada for PAs and has been accepted by the CMA Conjoint Accreditation Services as well as academic institutions, health facilities and many employers as the national standard of practice for PAs in Canada. CAPA's objective in the development of this document is to communicate to the public and to the PA profession a set of standards that all PAs are expected to acquire for entry to practice. It is intended to help employers, PAs, physicians, educators and others to understand the breadth and depth of practice for PAs in Canada.

This document provides the NCP, developed for entry-level Generalist PAs in Canada.¹¹ The NCP document is based on the CanMEDS model for competencies and objectives that has been adopted by the colleges responsible for certification of physicians in Canada: the RCPSC and the CFPC. It is only fitting that this same competency framework, adopted with the permission and assistance of these bodies, be used to define the PA profession in Canada. CAPA's NCP was adopted by HealthForceOntario (HFO) for the 2007 Practice Statement and Ontario PA Competency Profile used during the Ontario PA Demonstration Projects.

CAPA recommends that:

The CAPA Scope of Practice and National Competency Profile form the basis for all PAs practicing in Ontario.

¹¹CAPA. (2009). *Canadian Association of Physician Assistants Scope of Practice and National Competency Profile*. Retrieved from: http://www.capa-acam.ca/en/Scope_Of_Practice__National_Competency_Profile_55

With respect to the question regarding statistical data, CAPA will continue to work with other stakeholders to share the responsibility of collecting and sharing statistical information regarding members.

Leadership's Ability to Favour the Public Interest and Membership Support and Willingness of the Profession to be Regulated

CAPA has a membership consisting of 400 health professionals and PA students. This is small in comparison to other professional associations; however, considering the infancy of the PA profession in Canada it is understandable that the numbers are low. When CAPA was first created in 1991, with the assistance of the Department of National Defense, there were only a few members and 95 per cent were military. Since this time the association has grown significantly and became an independent organization in late 2009. In just a few years PAs have been extended from the Canadian Forces into the public and private health care system and are currently practicing in various hospital and clinic settings in Ontario, New Brunswick, Manitoba and Alberta.

CAPA members are extremely invested in the development of the PA profession in Canada. Evidence of this is in the number of members CAPA has in comparison to the number of practicing PAs in Canada. It is estimated that there are roughly 300 PAs practicing in Canada. Evidence of the membership's commitment to furthering the profession was apparent from the presence of 140 delegates at the CAPA Annual Conference as well as 99 members in attendance at the Annual Members Meeting. Again, these are high percentages considering that the CAPA membership is 400 including students. CAPA is committed to leading the advancement of the PA profession in Canada. CAPA has participated on a number of different committees in Ontario and throughout Canada supporting the introduction of PAs and advocating for regulation. Some of these include: the CMA PA Working Group, the CMA's Conjoint Accreditation Services and the Ontario Physician Assistant Implementation Steering Committee (PAISC). Terms of reference for these committees are provided in Appendix D. CAPA has been involved in a number of advocacy initiatives in an effort to further advance the profession including: meetings with provincial governments; political leaders and provincial medical associations. The association has also made outreach to other health professional groups and has been successful in attaining support from other bodies.

Public Interest

Enhancing patient care is a core fundamental value of the PA profession. CAPA's mission is to foster the development of the physician/PAModel to ensure quality care for Canadians; and improve access to that quality medical care. CAPA's code of ethics reflects the professions values which are centered on the public's and patients' well-being.¹² Academic PA programs are focused on safe quality patient care. In every task completed both in the theoretical and practical context, patient safety and trust is inherent as well as paramount. The physician/PA relationship is the best demonstration of how the public's interest is being served. The PA profession was in fact created with the intention of improving care for patients through the patient-centered physician/PA Model.

¹²The Canadian Association of Physician Assistants (CAPA). (2011). The Code of Ethics of the Physician Assistant Profession. Retrieved from: http://www.capa-cam.ca/user_files/users/25/Media/Code%20of%20Ethics_RevisedLS.pdf

CAPA members are also working hard to advance the profession in Canada and obtain great satisfaction knowing that what they are doing is making a positive contribution to patients. Regulation of the PA profession would ensure that the risk from harm to the public is mitigated by the establishment of a regulatory infrastructure and process to protect the patients of Ontario. It is the desire of CAPA members to see the PA profession regulated in Ontario in order to better ensure safety and to improve the quality of care that Canadians are receiving.

Evidence of the membership's support of regulation has been demonstrated on several occasions. At the CAPA Board of Directors (CAPA BOD) meeting in October 2011, a unanimous motion was passed approving the HPRAC submission process and to appoint the CAPA Ontario Chapter President, who also sits on the CAPA BOD, as the lead liaison in the application process. The subject of regulation was discussed at specific CAPA Regional Chapter meetings with the membership in October 2011. Additionally, during the CAPA Annual Members Meeting in October 2011, an announcement was made and members were informed of the HPRAC process and submission. In all cases, the membership was very supportive of the concept of regulation and pleased that the process was being undertaken in the province of Ontario.

Under the direction of CAPA's Ontario Chapter President as well as the Executive Director, a Regulatory Working Group including practicing PAs was established with the mandate to develop CAPA's HPRAC submission. The Regulatory Working Group has been instrumental in contributing to the completion of the HPRAC application. Evidence of this is in the individual qualitative case studies referenced in the Primary Criterion: Risk of Harm section of this document. Additional meetings have been held with individual PAs in Ontario, Manitoba, and New Brunswick for the purpose of the Primary Criterion: Risk of Harm and Secondary Criterion: Professional Autonomy portions of the application. Regulation would stabilize the profession in Ontario and it would also ensure that there is a system in place that protects the public. In addition, regulation would instill confidence within the public and potential employers and it would encourage physicians in Ontario to employ PAs with less hesitation and have a clear understanding of each of their roles. According to the HFO and the Canadian Forces, there are roughly 130 practicing PAs in Ontario, with regulation it is conceivable that this number could increase dramatically.

CAPA is aware of the cost associated for physician regulation under the CPSO. Based on the information gathered from the CPSO, the annual membership fee for a physician is \$1,485 plus an additional \$800 application fee for new physicians.¹³(The CPSO,2011)In Manitoba, the college of physicians and surgeons, the regulatory body for the PA profession in this province, has established an \$800 initial fee and an annual \$300 renewal fee for PA members. CAPA cannot guarantee that the membership in Ontario has the financial means to support such fees; however, given that the average annual compensation for a PA practicing in Canada is \$75,000 – \$125,000,one could assume that the regulating body would take this into consideration when establishing the annual fees.

¹³The College of Physicians and Surgeons of Ontario (CPSO).(2011). Fee schedule section, ¶ 1. Retrieved from:<http://www.cpso.on.ca/members/membership/default.aspx?id=1884>

Support from External Organizations

The CMA and Ontario Medical Association (OMA) are strong supporters for the integration of PAs into the Canadian health care system and for the regulation of the PA profession in Ontario. This is demonstrated not only by their involvement in the HPRAC application process but other initiatives such as OMA's involvement in the Ontario PA Demonstration Projects and the Ontario PA Grant Program. OMA was the lead organization for the Physician Employed PA (PEPA) Demonstration Project. The OMA partnered with the Ontario MOHLTC for the integration of PAs in Ontario. An OMA Board member was the co-chair for the Physician Assistant Steering Committee (PAISC). In addition, the CMA worked closely with CAPA and took a leadership role in accrediting the four Canadian academic PA programs through the CMA Conjoint Accreditation Services process. The CMA and OMA publically offer, and continue to offer, support in media outreach efforts on CAPA's behalf and have included the association in their campaigns. Both associations are strong supporters of CAPA and have a genuine interest in the advancement of the PA profession in Canada. The OMA has offered resources and acted in a consultative capacity to assist with the successful completion of the HPRAC application. CAPA formed a sub-committee for the review of this submission and members of the CMA, OMA, RCPSC, CPSO, The College of Physicians and Surgeons of Manitoba, the Consortium of Education, McMaster University, the University of Manitoba and all of their respective staff are active participants of this sub-committee and have contributed to the overall content included in this application.

The RCPSC is a supporter of the advancement of the PA profession in Canada. In 2008 during their September Council Meeting, the RCPSC formally affirmed its support for the PA profession by way of a formal resolution.¹⁴(RCPSC,2008)

The CFPC advocated for the PA Profession, in their 2011 *Position Statement on Physician Assistants*. The CFPC recognizes that PAs, under the supervision of a family physician practice, are among those professionals with the potential to augment access to family practice services/primary care.¹⁵(CFPC,2011)The CFPC makes specific mention of the inclusion of PAs in its proposed Patient's Medical Home Model noting; "PAs can have a positive impact on patients receiving timely access to high-quality primary care/family practice services".¹⁶(CFPC, 2011)

The Ontario Minister of Health and Long-Term Care, the Honourable Deb Matthews, recently demonstrated her support for the PA profession and recognized PAs as having a "crucial and significant role in Ontario's health system." It was further stated that "through a collaborative and patient-centered approach physician assistants are improving health care in Ontario."¹⁷

¹⁴Royal College of Physicians and Surgeons of Canada (RCPSC).(2008). *Council Meeting Minutes: September 22-23, 2008, Ottawa: Royal College*

¹⁵College of Family Physicians of Canada (CFPC).(2011). *Position Statement on Physician Assistants*. Retrieved from: http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/Health_Professionals/CFPC%20Position%20Statement_Physician%20Assistants_FINAL%20ENGLISH.pdf

¹⁶The College of Family Physicians of Canada (CFPC). (2011) *A Vision for Canada: Family Practice, The Patients Medical Home*. Retrieved from: http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf. , September 2011

¹⁷Letter from the Honourable Deb Matthews, the Ontario Minister of Health supporting Physician Assistants is provided in Appendix E.

Numerous health care facilities and physicians in Ontario have shown their continued interest in working with PAs by becoming involved in the MOHLTC's Ontario Demonstration Projects and funding opportunities to support the employment of PA graduates. These facilities have also taken an active role in training students within their facilities.

CAPA has consulted with the CPSO on the regulation of PAs in Ontario and is committed to working with the CPSP to facilitate a smooth transition once regulated.

Complaints and Disciplinary Action

A complaints and disciplinary procedure does not currently exist for the profession of PAs in Ontario. The Canadian Forces has established its own internal system, however, in the non-military context there is no formal process. Once regulated, such a system will be in place as mandated by the RHPA.

Health System Impact

Currently in Ontario 810,000 people are without a family physician.¹⁸ (Jacobson, 2011) This is largely due to the shortage of physicians in the province.

In the 2011 Auditor General's Annual Report to the Ontario Legislature, it is noted that "Along with alternate funding arrangements, the Ministry has established other initiatives to help people find a family physician. The Ministry estimated—on the basis of a survey it commissioned—that these initiatives have resulted in almost 500,000 more Ontarians having a family physician in 2010 than in 2007."¹⁹ (The Office of the Auditor General of Ontario, 2011)

The introduction of PAs in Ontario has the potential to have further positive impacts on increasing access to patient care. PA's working collaboratively with supervising physicians would allow for the concentration of the expert resources where needed thus enabling the physician to focus on more critical complex cases and potentially expand his/her practice to include additional patients. This team-based approach has proven to be essential to providing optimum health care where it is most needed.

Inter-Professional Collaboration

The very nature of the PA profession is built around the concept of inter-professional collaboration. The fundamental core of the profession is working in partnership with the supervising physician(s) for the benefit of the patient. The educational programs, policy, training manuals and standards, exemplifies inter-professional collaboration. In fact a PA is only able to practice with a supervising physician(s). Based on the physician/PA relationship the supervising physician(s) delegates a myriad of patient care responsibilities to the PA including: diagnosis; treatment; and/or patient care plans.

PAs not only work in collaboration with physicians but also with other health care professionals. In all health settings, the PA interacts and works with other team members to provide safe quality care to the patient. For example, the PA may consult a dietitian to provide services that would benefit his/her patient who has obesity issues or he/she may collaborate with a physiotherapist on site to help assess the extent of a particular patient's musculoskeletal problems. Working in a team-based setting, PAs are helping to make the system work for the patient and are contributing to increasing productivity. The CFPC paper on Patient's Medical Home Model describes the PA general and family practice relationship and how it works to benefit the patient.²⁰

¹⁸ Jacobson, Carol. OMA: [Internet] Message to: Natalie St-Pierre (CAPA). Dec 8 [cited 2011 Dec 9]. [1 paragraph].

¹⁹ The Office of the Auditor General of Ontario. (2011). *Annual Report: Funding Alternatives for Family Physicians* (Chap. 3, p. 150). Retrieved from: http://www.auditor.on.ca/en/reports_en/en11/307en11.pdf

²⁰ CFPC. (2011) *A Vision for Canada: Family Practice, The Patients Medical Home Model*, p.11. Retrieved from: http://www.cfpc.ca/A_Vision_for_Canada_abridged_version/

A study conducted by the Orthopaedics Division at the University of Manitoba revealed that PAs saved their supervising physician, on average, 204 hours per year. Further, in this setting, the physician/PA team was able to increase the volume of primary joint procedures by 42 per cent and was able to decrease wait times for orthopaedic surgeries by 32 percent.²¹(Bohm, Dunbar, Pitman, Rhule and Araneta, 2009)

In Ontario, a study was performed by McMaster University on PAs employed in emergency departments. The findings showed that utilizing PAs in the emergency department reduced wait times for patients by 1.6 times and reduced the "left without being seen" rate by 24 percent. The study indicates that "the reductions found in wait times and left without being seen rates suggests that the presence of new roles can help to improve the efficiency of emergency department patient care". The study also recommends that "given the shortage of physicians, use of alternative health care providers should be considered."²²(Ducharm, Adler, Pelletier, Murray and Tepper, 2009)

The benefits of the integration of PAs into the Ontario health system are supported in this study. The regulation of PAs would facilitate the continued introduction of the profession and would ensure that there is a system in place that protects the public. Regulation will make it easier for other health professionals working with PAs to accept their profession and assist in reassuring those individuals who may hold objection towards the profession.

Labour Mobility

PAs are regulated in the province of Manitoba and New Brunswick by each province's respective college of physicians and surgeons. There is a PACCC PA Cert Exam which is administered and managed by the PACCC. PAs are not required to write the PA Cert Exam as a condition for practice in Ontario.

CAPA recommends that:

Successful completion of the PACCC PA Cert Exam, resulting in being awarded the CCPA designation be a requirement for practice for PAs in Ontario.

This would ensure that all PAs have met the established national standard for the profession. In Manitoba and New Brunswick the profession is regulated. Specific controlled acts are not listed under the PAs NCP. In the legislation provided by the provincial colleges, PAs are permitted to perform controlled acts that are delegated by their supervising physician(s) under the provincial Medical Acts. In order to avoid inconsistencies in the various provinces and to promote labour mobility in Canada, CAPA would make the following recommendation.

²¹Bohm, Dunbar, Pitman, Rhule and Araneta . (2009). Experience with physician assistants in a Canadian arthroplasty program. *Can J Surg*, Vol. 53, No. 2, p. 460. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845948/>

²²Ducharm, Adler, Pelletier, Murray and Tepper.(2009). *Impact on patient flow after the integration of nurse practitioners and physician assistants in Ontario emergency departments*. *Canadian Journal of Emergency Medicine*, p. 107 – 108. Retrieved from: <http://www.cjem-online.ca/v11/n5/p455>

CAPA recommends that:

The established regulatory body for PAs in Ontario adopts the model used by the college of physicians and surgeons in Manitoba with respect to controlled acts.

In Canada there are four academic programs that offer a Physician Assistant Education Program. New graduates are entering the workforce every year. Regulation of the profession could potentially create more employment opportunities for these new graduates as well as retired Canadian Forces personnel. As new employment opportunities are created for PAs there will be qualified individuals to fill these positions. Once regulated, prospective employers may be further inclined to employ PAs in their health institutions due to the fact that regulation would add credibility and validate the profession.

Productivity

CAPA is not aware of any documented evidence on productivity with respect to the domains of psychosocial and quality of life in Ontario. CAPA has presented positive outcomes from a clinical perspective as referenced in the two studies listed in the inter-professional collaboration section of this paper. Based on input from the MOHLTC, the Evaluation of the PA Demonstration Projects has demonstrated positive results. The interim findings show: supervising physicians and PA satisfaction; no negative impact on patient safety; and positive benefits to access to patient care. It is anticipated the final report will be sent to the MOHLTC in the near future. CAPA does not know whether this information will be made public.

Conclusion

CAPA is confident that regulation of the PA profession in Ontario would offer considerable benefits to the Ontario health care system. Regulation would not only enhance access to quality care for Ontarians but would also ensure that there is a system in place which further reinforces patient safety. To have a recognized provincial regulatory body overseeing PAs in Ontario would reassure other health professionals and employers there is a system of checks and balances in place to protect the public interest.

Regulation of the profession would foster inter-professional collaboration between various health professionals. By validating the profession, CAPA anticipates that other health care professionals would be more supportive of working with PAs and more inclined to respect the professionals employed in these positions. As we move closer to a team-based health care delivery model in Ontario this relationship between the PA and other health care providers becomes crucial for patients in receiving quality care.

CAPA would like to acknowledge the OMA, CPSO, HFO, McMaster University, the University of Manitoba, the Canadian Forces Health Services Training Centre, the Consortium of PA Education and the HPRAC sub-committee members for their assistance in preparing this application; as well as the CMA for their support in gathering the information required for the completion of this submission. Additionally, CAPA would like to express their gratitude to HPRAC and the Minister of Health, the Honourable Deb Matthews, for the opportunity to submit an application for regulation of the PA profession in Ontario.

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CANADIAN FORCES HEALTH SERVICES TRAINING CENTRE

PHYSICIAN ASSISTANT PROGRAM

Program Overview

The Canadian Forces Physician Assistant Program began its present format in 2004 and was the first Canadian program to be accredited by the Canadian Medical Association (CMA). The program leads to a Bachelor of Sciences by the University of Nebraska.

The program ensures that all candidates are prepared IAW the National Competency Profile (NCP) 2009 and are eligible to write the National Certification examination.

The educational goals of the PA Program are as follows:

- a. to provide candidates with the basic sciences requisite to understanding medicine, in an educational model that is in line with physician education;
- b. to instruct candidates in techniques necessary for comprehensive patient assessment including history taking and physical examination;
- c. to provide candidates with principles of clinical pharmacology and pharmaco-therapeutics in order to initiate appropriate pharmacotherapy in accordance with the NCP and Restricted Acts Pharmaceuticals;
- d. to provide candidates with comprehensive knowledge of conditions, affecting all segments of the population, diagnosis and treatment;
- e. to provide candidates with the principles of scientific inquiry and research design, the ability to apply these principles, to read critically and interpret the literature in order to enhance health care delivery; and
- f. to prepare candidates to analyze and critically interpret information and formulate appropriate decisions.

The clinical goals of the PA Program are as follows;

- a. to offer an educational experience from which candidates can learn to provide primary and specialized health care services in a variety of settings, under the direction of a supervising physician.
- b. to provide hands on learning and supervision by physician clinical supervisors in a variety of clinical settings.
- c. to attain NCP competencies;
- d. to develop interpersonal skills that allow them to interact with patients and health care team members effectively, ethically and with empathy; and

- e. to foster ethical and moral behaviour, attitudes and skills which are required for personal growth and growth and development of the profession.

Description of Scope

The course scope includes:

- a. Phase 1: 12 months of academic learning and simulation training;
- b. Phase 2: 46 weeks of clinical rotations;
- c. Phase 3: OSCE-style testing.

Outline of Training

Training for the Physician Assistant Qualification is achieved by means of formal course. The Course is based on the performance-oriented concept of training and emphasizes realism consistent with available resources and conditions. Military aspects of medicine are emphasized throughout the course wherever possible.

Accreditation

The Program is accredited by the CMA for a 6 year term in September 2010.

Certification

Graduates qualify to take the National Certification of the Canadian Association of Physician Assistant.

1. Introduction

The Bachelor of Science Physician Assistant degree (BScPA) is a full-time professional, second-entry undergraduate degree program based in the Department of Family and Community Medicine (DFCM) in the Faculty of Medicine at the University of Toronto (UofT). The BScPA is a University of Toronto degree delivered in collaboration with Northern Ontario School of Medicine (NOSM) and The Michener Institute for Applied Health Sciences (Michener). The three institutions have formed the Consortium of PA Education (Consortium) to collaboratively contribute in the development, administration and delivery of the UofT degree. Academic Year 2010/2011 was the second year of operation, with the first cohort scheduled to complete the program December 2011. Convocation is planned for June 2012.

The member institutions of the Consortium, the Faculty of Medicine and the home department (DFCM) provide, by way of their individual Missions, Visions and Values overarching direction for the BScPA Program. The Mission, Guiding Strategies and Core Values of the Consortium of PA Education guide the foundation for our program outcomes and goals.

1.1. Mission

Our mission is to deliver Physician Assistant education programs built on a foundation of social accountability, particularly to rural, remote and underserved communities

1.2. Guiding strategies

The Consortium of PA Education is guided in the development of the professional degree programs by the following core strategies:

1. **The collaboration of multi-institutional delivery of innovative professional degree programs**, by way of academic excellence, simulations and interprofessional education, and diverse clinical placements
2. **The optimization of technology to support and deliver leading-edge curriculum**, including web-based, audio-visual, experiential simulation and distance education technologies
3. **The commitment to educate PA students and to encourage and support clinical experiences in rural, remote and underserved areas**, in order to increase access to healthcare throughout Ontario

1.3. Our core values

To equip graduates with the capability to establish a sustainable Canadian PA professional identity based on principles of:

1. **Social accountability** – contributing to a sustainable healthcare system
2. **Professionalism** – that entails the establishment of an identity for PAs in a variety of healthcare settings, focusing on primary care
3. **Interprofessional collaboration** – that includes the advancement of collaborative patient-centred practice
4. **Critical thinking and life-long learning** – that enhances the effectiveness of services provided by physicians and other members of the healthcare team

2. Admission Requirements

2.1. Academic Requirements

- Two full years university undergraduate studies; 10 full-course credits (or equivalent); any discipline
- Demonstration of English Language proficiency as per UofT Office of Admissions and Awards

2.2. Non-academic Requirements

- Canadian Citizen or permanent resident
- Access to high speed internet
- Experience as a Health Care Professional in good standing
 - Minimum 1680 hours of direct patient contact in a professional setting
 - Volunteer hours cannot be attributed to the 1680 hours of professional experience
 - Applicants are directed to a list of health occupations that are officially identified by Human Resources and Skills Development Canada

2.3. Preferred Criteria

- Current Ontario resident
- Recent health care experience (within the last 5 years)
- Cumulative average GPA of at least 3.0 on the OMSAS (Ontario Medical Schools Application Service) 4.0 scale
- Three prerequisite courses (at the post-secondary level, i.e. university OR college)
 - Human Anatomy
 - Chemistry
 - Physiology

3. Curriculum

The BScPA Program is a distance and distributed education program with the majority of the program delivered on-line. Students are expected to participate in on-line learning from home throughout Year 1 in the program. Students are required to attend classroom and lab-based sessions held face-to-face in Toronto at specific intervals within both Year 1 and Year 2. These “Residential Blocks” are used for simulation-based learning and assessments, for skills development, and for integration with other health professions learners for inter-professional education opportunities. During Year 2, students focus on learning in clinical placements, with rotations in both Northern and Southern Ontario.

3.1. Program Overview

Year 1 (3 semesters)

15 courses in total, including 120 hours of longitudinal clinical experience

- 16 weeks total of Residential Blocks:
 - January
 - April
 - August
 - November/December

Year 2 (3 semesters)

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Rotations in Northern Ontario and in southern Ontario; Rotations in “Home- Training Location” and in “North-South Swap Training Location”

- 40 weeks of supervised direct clinical placements
- 2 Rotations in Primary Care
 - In distinctly different communities
 - Scheduled at start and at end of clinical year
- 4 week rotations in Specialties:
 - Emergency Medicine
 - Internal Medicine
 - Surgery
 - Mental Health
 - Woman’s Health (OB-GYN)
 - Pediatrics
- 3 week elective
- 6 weeks total of Residential Blocks:
 - March
 - May/June
 - October
- 4 academic on-line courses delivered throughout Year 2

3.2. BScPA Program Model Route

Course Code	Course Name	Credits
YEAR 1		
Semester1 (Winter: January – April)		
PAP 111H1	Introduction to the Physician Assistant Role	0.5
PAP 112H1	Anatomy	1.0
PAP 113H1	Physiology	1.0
PAP 114H1	Clinical Skills I	1.0
PAP 130H1	Longitudinal Clinical Experience	
Semester 2 (Spring: May – August)		
PAP 125H1	Diagnostic Techniques and Procedures I	0.25
PAP 124H1	Clinical Skills II	0.25
PAP 127H1	Pharmacology	0.75
PAP 122H1	Pathology	1.0
PAP 130H1	Longitudinal Clinical Experience	
Semester 3 (Fall: September – December)		
PAP 134H1	Clinical Skills III	0.5
PAP 131H1	Primary Care Medicine I	2.5
PAP 138H1	Behavioural Medicine	0.25
PAP 135H1	Diagnostic Techniques and Procedures II	0.25
PAP 130H1	Longitudinal Clinical Experience	<i>Credit/No Credit</i>
YEAR 2		
Semester 4 (January – April)		
PAP 241H1	Primary Care Medicine II	
PAP 258H1	Health Promotion and Education	

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PAP 250H1	Clinical 1	
Semester 5 (May – August)		
PAP 241H1	Primary Care Medicine II	0.8
PAP 258H1	Health Promotion and Education	0.2
PAP 250H1	Clinical 1	2.0
PAP 260H1	Clinical 2	
Semester 6 (September – December)		
PAP 265H1	Evidence Based Medicine	0.25
PAP 269H1	Medical Ethics	0.5
PAP 260H1	Clinical 2	2.0

4. Quality of Faculty

4.1. Didactic Teaching

The BScPA curriculum is delivered by a variety of individuals, with various affiliations and expertise.

The BScPA Program core teaching faculty includes:

- Medical Director (0.8 FTE)
- Academic Coordinator (1.0 FTE)
- Clinical Coordinator (1.0 FTE)
- Lecturer (0.75 FTE)

The Medical Director is a licensed academic Family Physician with a Masters in Education, with relevant expertise and qualifications to oversee the Program. The Academic Coordinator (AC) and the Clinical Coordinator (CC) are Canadian certified Physician Assistants with clinical work experience and academic proficiency relevant to their current positions. Our AC is a PA educated in the US and certified there as well as in Canada. She is a full time UofT faculty member pursuing an MSc CH in the Department of Family & Community Medicine (DFCM). Our CC is a military trained PA certified in Canada. He is a full time NOSM faculty member, currently pursuing his MPAS from the University of Nebraska. Our CC has vast experience in clinical education through his previous work in the military PA program.

Course Directors, Teaching Assistants and guest teachers include:

- Clinical Faculty (academic physicians) with appointments in their respective departments
- University faculty in Basic Sciences, other faculties (Pharmacy, Nursing, Social Work)
- Physician Assistants in the community
- Allied Health Professionals in the community

The BScPA Program ensures that the didactic personnel have the relevant professional certification/registration or academic qualifications to fulfill their role in supporting learning. We involve the expertise of certified Physician Assistants, physicians, educators, allied health professionals and content experts in the development and delivery of the curriculum.

Students complete faculty assessments regularly. At the end of each course, students complete a faculty assessment survey, and during and at the end of Residential Block teaching, students complete satisfaction surveys on guest and visiting teachers.

Currently, discussions at Curriculum Committee meetings provide the Program with faculty feedback. A survey is being developed for faculty to provide anonymous feedback on their experiences within the program.

The BScPA Program facilitates the professional development (PD) of our teaching staff and preceptors through a variety of avenues, including developing our own, specific to our needs as well as utilizing resources available within the institution and beyond.

4.2. Clinical Teaching

Clinical Preceptor teaching personnel includes:

- Fully certified, licensed physician supervisor or group of physicians
- Medical education office or coordinator affiliated with the clinical site

Clinical teaching faculty with a university appointment are expected to maintain their profession's continuing education (CE) requirements in order to maintain ongoing certification/registration. Physician Assistants, as members of CAPA, are required to complete 250 hours of continuing professional education per five-year cycle. Members of the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada, are similarly required to maintain certification through continuing professional education.

Preceptor assessment forms are completed by the students at the end of each rotation to assess the preceptor(s) in the context of the clinical education environment. These evaluations are reviewed by the Clinical Coordinator and the Medical Director, and released to the clinical sites once student anonymity can be protected (e.g. collation of evaluations from three or more students).

5. Accreditation

The Canadian Medical Association (CMA) is the body that offers accreditation to Physician Assistant education programs in Canada. The BScPA Program has applied for Accreditation status in 2011. Phase I of the process was submitted for review in April 2011. The site visit by the survey team, Phase II, occurred in September 2011. The Program received notification in October 2011 that the Program will be recommended for 2 year accreditation status to the CMA before the end of the 2011 calendar year.

New programs that do not have graduates to date are only eligible to achieve a maximum of a two year accreditation status. Once graduate results on the national exam become available, the accreditation body will consider reviewing the program for approval for a six year period.



Physician Assistant Education Program

University of Manitoba Physician Assistant Education Program (PAEP)

The University of Manitoba Physician Assistant Education Program (PAEP) is the first and only graduate-level program for Physician Assistant education offered by a University in Canada. Upon completion of all components of the comprehensive 25 month program, graduates receive a Master of Physician Assistant Studies (MPAS) degree from the Faculty of Graduate Studies.

The University of Manitoba Physician Assistant Education Program focuses on preparing outstanding clinical professionals who will extend the delivery of quality health care services to the citizens of Manitoba and Canada, advance the academic field of the profession, and foster PA leaders who will serve their communities while advancing the profession. The program integrates graduate-level critical thinking and analysis into its approach to case-based learning, and scientific inquiry in the practice of patient-centered team medicine. This approach prepares graduates for the demands of modern practice in a rapidly changing health care environment. A team approach to health care is emphasized not only in clinical practice but also in research, leadership, education, and continued professional development. The PAEP graduates are provided a medical education for generalist medical practitioners with a focus on the knowledge and skills required by Primary Care Providers and Community Hospitalists.

The PAEP is housed within the Faculty of Graduate Studies and administered through the Faculty of Medicine at the University of Manitoba. The PAEP incorporates the concepts of student centred learning, adult learning principles, and professional education with the clinical competencies necessary for effective physician assistant practice. The primary goal of the PAEP is to ensure that graduates meet the competencies outlined in the National Competency Profile (NCP) developed by the Canadian Association of Physician Assistants (CAPA). In keeping with this goal, the pedagogical and ideological foundations of the PAEP are the CanMEDS competencies, on which the national NCP is based, and the Four Principles of Family Medicine developed by the College of Family Physicians of Canada (CFPC). The PAEP consists of basic medical and clinical sciences followed by clinical rotations. The Academic First Year is delivered over three semesters; while the Clinical Year rotations are completed at a variety of clinical teaching units in Winnipeg, throughout the province, and at selected sites across Canada.

PAEP CURRICULUM

Academic Year

Pharmacology through 2 Semesters
Human Anatomy for PAs 1 Semester

Physiology and Pathophysiology 2 Semesters
Professional Studies for PAs 1 Semester

Biochemistry for PAs 1 Semester	Research and Clinical Practice 1 Semester
Genetics for PAs 1 Semester	Patient Assessment for PAs 3 Semesters Principles of
Psychiatry for PAs 1 Semester	Adult Medicine for PAs 2 Semester (12 Credits) Obstetrics & Gynaecology
for PAs 1 Semester	Diagnostic Imaging for PAs 1 Semester Microbiology for PAs 1 Semester
Principles of Surgery for PAs 1 Semester Paediatrics for PAs 1 Semester	Emergency
/ Critical Care 1 Semester Curriculum Integration 3 Semesters	

Comprehensive Examination (Academic Year): This summative examination assesses learners' knowledge of clinically relevant didactic material prior to entry into clinical training. Successful completion is required in order to advance.

YEAR 2 Clinical Rotations

Family Medicine for Physician Assistants	12 Weeks
Internal Medicine for Physician Assistants	4 weeks
Surgery for Physician Assistants	4 weeks
Orthopaedic & Sports Medicine for Physician Assistants	4 weeks
Paediatrics for Physician Assistants	4 weeks
Clinical Psychiatry for Physician Assistants	4 weeks
Emergency Medicine for Physician Assistants	4 weeks
Obstetrics & Gynaecology for PAs	4 weeks
Anaesthesia for Physician Assistants	2 weeks
Electives for Physician Assistants	4 weeks

Comprehensive Assessment of Clinical Skills (CACS) and a Capstone Project (Graduate Thesis) involving Critical Analysis Research or Clinical Quality Improvement project are required to be successfully completed before completion of the program and awarding of the Master of Physician Assistant Studies degree.

McMASTER PROGRAM OVERVIEW

McMaster was one of the first institutions in Canada to launch a Physician Assistant Education Program in 2008. The PA Education program leads to the Bachelor of Health Sciences (Physician Assistant) degree. The program is taught using inquiry and problem-based learning, which enhance each student's ability to think critically, solve problems, demonstrate initiative and independence in practice, and promote lifelong learning.

MISSION STATEMENT

The mission of the McMaster University Physician Assistant Education Program is to educate energetic, innovative, committed and caring individuals to become role models in a new health care delivery model practicing medicine under the supervision of a physician to expand health care access for the people of Ontario.

Curriculum Plan

The twenty-four month program begins in September. The first year focuses on the study of the clinical sciences underpinning health care delivery. In the second year, students enter into clinical placements.

YEAR 1: CLINICAL SCIENCES

The clinical sciences curriculum is modeled on the McMaster Medical School Curriculum and is designed to meet the competencies outlined in the *Canadian Association of Physician Assistants National Occupation Competency Profile* and the Canadian Medical Association accreditation standards. The curriculum is delivered in small group problem-based learning modules with a focus on the physician assistant's role in health care and the promotion of inter-professional education and training.

The clinical sciences curriculum consists of three Medical Foundations, each composed of four components:

1. Clinical Sciences (Tutorial)
2. Interviewing, Examination and Reasoning (IER)
3. Professional Competencies (ProComp)
4. A series of half-day multidisciplinary clinical observerships

Medical Foundation 1 (MF1)

- Clinical Science: Oxygen Transport: cardiovascular, respiratory and hematologic physiology and disease.
- IER: Basic communication skills, history taking and physical examination.
- ProComp: Professionalism, the role of the PA, principles and structure of the health care system, chronic disease, determinants of health

Medical Foundation 2 (MF2)

- Clinical Science: Homeostasis: energy balance, GI, endocrine, nutrition, fluid and electrolyte balance (including renal, acid base, BP) and reproduction, and pregnancy

- IER: Continued development of communication skills, history taking and physical examination with additional focus on GI, endocrine and obstetric and gynecologic systems.
- ProComp: Medical ethics and medical decision making.

Medical Foundation 3 (MF3)

- Clinical Science: Infection, cancer, neurologic, psychiatric and musculoskeletal physiology and disease
- IER: Continued development of communication skills (negotiation and conflict resolution), history taking and physical examination with additional focus on the neurologic, psychiatric and musculoskeletal systems.
- ProComp: Standards of care, laws and codes relevant to medical practice, institutional policies, mental health and society, breaking bad news, end of life decision-making, resource allocation

YEAR II: CLERKSHIP

In the second year students undertake 48 weeks of supervised clinical placements. Core experiences take place in family medicine, medicine, surgery, emergency medicine and psychiatry. Elective placements round out the balance of the clinical year and allow students to pursue additional and career interests.

The goals of the PA clerkship are similar to those of clerkship in the M.D. Program:

- Develop an increasing facility in taking histories;
- Develop increasing ability in doing physical examinations;
- Learn to develop a plan of investigation or management of the patient problem;
- Become familiar with documenting patient encounters and plan;
- Become skilled in communicating with the patient and the supervising physician;
- Under supervision, initiate investigation and management.

ACCREDITATION

Program accredited by the CMA, June 2010.

CERTIFICATION

Graduates who qualify to take the national Physician Assistant certification examination.

WEB ADDRESS: <http://fhs.mcmaster.ca/physicianassistant/>



CANADIAN ASSOCIATION OF PHYSICIAN ASSISTANTS

**POSITION STATEMENT
CONCERNING PHYSICIAN ASSISTANT REGULATIONS FOR
PRACTICE IN CANADA**

It is the Canadian Association of Physician Assistants (CAPA) desire to work closely with provincial governments, regulatory agencies, medical associations, and others to facilitate the introduction and integration of Physician Assistants (PAs) in Canada's health care system with the goal of improving access to quality care and ensuring public safety. This position paper's intent is to provide a point of reference that provincial regulatory agencies can use to develop Physician Assistant regulations in a uniform manner across Canada.

The Canadian Association of Physician Assistants advocates for the Physician/Physician Assistant Model of patient centred health care. CAPA's mission includes advocating for the PA profession, defining the body of knowledge known as the National Competency Profile (NCP) required for PA education programs and administers the national PA Entry to Practice Certification Examination through the Physician Assistant Certification Council of Canada (PACCC). Canadian Physician Assistant education programs are accredited through the Canadian Medical Association's Conjoint Accreditation Services. Certified PA's, through CAPA track their continuing professional development and maintain their national certification. Canada's PAs have produced and support a code of ethics that places public before self interest.

It is our members' desire that provincial regulations governing the PA practice serve to protect the public by providing a mechanism to ensure accountability for actions; and to define the role of PAs in the provincial health care system. To achieve these points, regulation should address:

- The need for the education of Physician Assistant students to include seeing and evaluating patients under the direct supervision of a licensed and qualified medical preceptor;
- Define the qualification and credentials associated with the use of the title of Physician Assistant and Canadian Certified Physician Assistant;
- Identify and clarify the relationship between the Physician and the Physician Assistant;
- Establish a contractual agreement that defines the nature of delegated tasks appropriate for a Physician Assistant; and
- Establish clear lines of communication, oversight, and appropriate consultation between the Physician Assistant and supervising physician.

Canada's Physician Assistants (PAs) are academically prepared and highly skilled health care professionals educated in the medical model that practice medicine under the supervision of a licensed physician within a patient-centered health care team. PAs possess a defined body of knowledge including clinical and procedural skills, and a professional philosophy to support effective patient care. They apply these competencies to collect data and interpret information, develop and further investigate differential diagnoses, make appropriate clinical decisions, and carry out required diagnostic, procedural, and therapeutic interventions. They practice medicine within a formalized physician/Physician Assistant relationship. It is important to note that PAs supplement, not supplant, the work of physicians as both a philosophy of the profession, and reality of clinical practice.

The nature and scope of the clinical patient care and medical practice provided by a Physician Assistant is to provide medical management defined as the planning, organizing, directing and controlling of the patient centric scientific approach to the diagnosis, treatment and prevention of disease within a formalized collaborative structure with physician oversight and regulation.

The CAPA Board of Directors recommends six key elements for the development of any regulation or registration of Physician Assistants.

A) "Licensure" as the Regulatory Term

No individual may practice medicine without permission granted by legislative authority. This permission is granted and regulated through the provinces' health professions or medical act. Such permission is conditioned on the meeting of certain criteria, which may include: passing an examination; possession of certain educational credentials; and other defined qualifications.ⁱ Collectively those acts, defining criteria, and permission to provide them are referred to as regulatory acts.ⁱⁱ Licensure recognizes the individual as holding permission to practice regulated acts. Regulatory terms should be descriptive, accurate, and understandable.

Licensure neither creates nor implies independent practice for Physician Assistants. Issuing licenses to Physician Assistants require PAs to practice with physician supervision; consistent with the profession's philosophy and definition. A granted privilege to practice medicine with implied and established responsibilities can be revoked and regulated as needed. The designations of "Full" and "Provisional" status would address the graduate PA who is waiting for the opportunity to challenge the national PA Entry to Practice Certification Examination while "Educational" status provides the PA student the opportunity to learn in clinical settings.

Many Canadian provincial and American state laws refer broadly to "licensed health professionals". The implied intent is to ensure inclusion in requirements to report certain injuries to law enforcement, child protective services, or participation in loan or service repayment programs. When a natural disaster or common emergency occurs it is important to have a mechanism allowing an executive order for all "licensed" health professionals to assist in providing care to those affected.

Different jurisdictions use different terminology such as in Ontario where physicians are issued a certificate of registration through the College of Physicians and Surgeons of Ontario. The College of Physicians and Surgeons of Manitoba registers and licenses PAs as associate members. In order to ensure that PAs are included in those laws, CAPA members request that the PA practice acts use the term "licensure" to describe the process by which the regulatory agency authorizes PAs to practice. The intent is a formal process that grants the privilege of practice with recognized rules and regulations.

CAPA supports reserving the term "certification" and "certified" for Physician Assistants who have successfully completed the Canadian Physician Assistant Entry to Practice Certification Examination (CCPA) administered by the Physician Assistant Certification Council of Canada (PACCC).

American PAs qualify for the designation Physician Assistant- Certified (PA-C) granted by the National Commission on Certification of Physician Assistants (NCCPA). Graduates of the American Accreditation Review Commission - Physician Assistant (ARC-PA) programs are eligible to challenge the Canadian Physician Assistant Entry to Practice Certification Examination.

B) Scope of Practice Determined at Practice Site

The Canadian Association of Physician Assistants' Scope of Practice and National Competency Profile respects the unique competency of the physician. The delegated practice of the PA must be consistent with the training and experience of the PA and qualifications and specialty of the supervising physician. The designated responsible physician is in the best position to evaluate the individual PA's abilities and to delegate procedures and services which are appropriate to both the PA and the nature of the practice.

Provincial laws, through regulation of practice, may include a list of overall services that PAs can provide. These services should be based on the Canadian Association of Physician Assistants Scope of Practice and National Competency Profileⁱⁱⁱ. Requiring the scope of practice of each individual PA to be approved by the regulating college or medical board restricts the ability of supervising physicians and Physician Assistants to customize Physician/Physician Assistant Team practice. A protocol heavy approach creates a needless administrative burden on the practice and regulatory agency. These restrictions lead to inefficiencies and limited access to care when situations change or warrant. To avoid this, the law should require that the supervising physician and PA jointly establish a written agreement outlining the PA's scope of practice that is approved by the physician(s). Any new procedure or skill set is authorized by the physician(s) who shares responsibility. This agreement is kept on site and a copy with the regulatory agency. For PAs that practice in a medical facility, scope of practice would also be defined by privileging decisions made by the facility.

C) Adaptable Supervision Requirements

Physician supervision and collaboration are fundamental aspects of PA practice and a key component in PA culture is the recognition of personal limitations. If PAs are to practice in the most efficient and effective way possible, it is essential that regulation or governing legislation do not delineate restrictions that may work well in some practices but not in others. A more adaptable approach allows the physician/PA teams to provide better care to more patients thereby improving access to quality care. In some settings, it makes sense for the supervising physician to be on-site when the PA is providing services, such as procedures on critically ill patients or in surgical environments. It is appropriate for the physician(s) who knows the PA's experience and competence to judge when the ability and situation require oversight. The risk of harm, with appreciation for experience and qualifications, should be the deciding factor for what can be delegated.

Graduate Physician Assistants who have yet to pass the PA Entry to Practice Certification Examination should have the requirement of on-site physician supervision.

Remote service is a clinical reality for Canada's Physician Assistant. The ability to provide these services is supported by the example of the Canadian Military on ships, deployments, and overseas operations. Supervising physicians, or their alternate, should always be immediately available via telecommunication and must be within a degree of physical proximity appropriate to the practice setting^{iv}

D) Prescriptive Authority

Physician Assistants derive their prescriptive authority from delegation by a supervising physician. The Pharmaceutical Act (C.C.S.M. c. P60 Assented July 26, 1991; updated February 2004) does not make specific reference to Physician Assistants but rather refers to "medical practitioner" meaning "a person licensed to practice medicine in a province or territory of Canada".^v In a literature review of Canadian pharmacy legislation the prescriptive authority in most jurisdictions was enabling with no restrictors limiting scope of practice or prescriptive authority to physicians only.^{vi} Prescribing medications, including controlled substances such as narcotics, is integral to the practice of medicine. Provincial legislation concerning prescriptive authority would require a review to ensure compliance with recent amendments.

The ability to prescribe is essential to the current practice of medicine and therefore essential for effective practice by Physician Assistants. Limiting prescriptive authority for Physician Assistants to a set of pre-approved medications will interfere with the ability to adapt to situations or the developing knowledge base. As the practice of medicine is dynamic predefined lists interferes with and will require consistent administrative attention.

E) Chart Co-Signature Requirements Determined at the Practice

Physician co-signature should be required only when the supervising physician, the PA, or the facility determines that it is necessary. A formal practice contract developed within guidelines established by the regulatory agency should provide the authority required for the PA to practice. This determination should be based on several factors unique to the practice including: the experience of the PA; the complexity of the patient population; and risk of harm.

Allowing the PA signature authority on medical-legal forms, certifications, and reports will allow and enhance the efficiency of a PA to assist the physician in the administrative nature of the profession. Forms such as those dealing with Workers Compensation, Disability, or Canadian Pension are several examples of what a PA should be allowed to complete in the best interest of the patient and physician practice. Several American states are enacting the "Big Bill" approach to PA legislation which simplifies wording and recognizes the qualifications of the Physician Assistant. New York recently passed a Public Health Bill which clarifies the scope of practice of Physician Assistants while under the supervision of a physician to perform the medical services that the physician could perform if the PAs have completed the proper training.^{vii} Functions are defined to include completion of medical-legal documentation unless identified as physician only.

A PHYSICIAN ASSISTANT MAY PERFORM ANY FUNCTION IN CONJUNCTION WITH A MEDICAL SERVICE LAWFULLY PERFORMED BY THE PHYSICIAN ASSISTANT, IN ANY HEALTH CARE SETTING, THAT A STATUTE AUTHORIZES OR DIRECTS A PHYSICIAN TO PERFORM AND THAT IS APPROPRIATE TO THE EDUCATION, TRAINING AND EXPERIENCE OF THE REGISTERED PHYSICIAN ASSISTANT AND WITHIN THE ORDINARY PRACTICE OF THE SUPERVISING PHYSICIAN. THIS SECTION SHALL NOT BE CONSTRUED TO INCREASE OR DECREASE THE LAWFUL SCOPE OF PRACTICE OF A PHYSICIAN ASSISTANT UNDER THE EDUCATION LAW.

STATE OF NEW YORK STATUTORY CONSTRUCTION. BILL NO. S0998A

F) Number of PAs a Physician May Supervise Determined at Practice Level

Provincial laws and regulation should not include a specific numerical limit on the number of PAs that one physician may supervise. The appropriate number of PAs that one physician may supervise should depend on several factors that are unique to each individual situation including: the training and experience of the PA(s) being supervised; the nature of the practice; the complexity of the patient population; and the physician's supervisory approach. As the director of the medical team, the supervising physician is in the best position to evaluate these factors.

In many primary care settings, a supervising physician can adequately supervise multiple PAs. In a complex surgical setting, a physician might appropriately choose to supervise only one PA. A regulation or law that applies the same limit to all specialties and clinical settings cannot account for these differences. Any physician-to-PA(s) ratio in statute will be too high for some clinical settings and too low for others. This principle that physicians at the practice level should determine the number of PAs they supervise is supported by several national medical organizations that are involved with American PAs including: the American Medical Association^{viii}; the American College of Emergency Physicians^{ix}; and the Society of Hospital Medicine^x

Ensuring that each PA has the ability to continuing practice if the supervising physician is absent requires that one or more alternative physicians who share call be identified in the practice contract.

Conclusion

Physician Assistants are part of the solution to address the shortage of qualified human health care resource and for improving access to quality care in Canada. Developing a regulatory framework that is effective, economical, and efficient provides better patient-centred health care. The goals of PA regulations or regulatory framework must protect the public, and define the PA role in the provincial health care system.

Additional Readings, References, and Resources

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American Academy of Physician Assistants. *Guidelines for state regulation of physician assistants* (2009).

American Academy of Family Physicians. *Guidelines on the supervision of certified nurse midwives, nurse practitioners, and physician assistants* (2008).
<http://www.aafp.org/online/en/home/policy/policies/n/nonphysicianproviders.html> (11 October 2011)

American Academy of Physician Assistants. *Issue brief: physician assistants as providers of controlled Medications* (2009).

ⁱ The Medical Act, Regulation 183/99, Clinical Assistants and Physician Assistants Regulation (Manitoba).
<http://web2.gov.mb.ca/laws/regs/pdf/m090-183.99.pdf> (11 October 2011); *Regulated Health Professions Acts, 1991* (Ontario). http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm (11 October 2011); *Health Professions Act* (Alberta). http://www.qp.alberta.ca/574.cfm?page=h07.cfm&leg_type=Acts&isbncln=9780779738083 (11 October 2011)

ⁱⁱ *Statutory Instruments Act R.S.C., 1985, c. S-22*.
<http://laws-lois.justice.gc.ca/eng/acts/S-22/page-1.html#h-1> (11 October 2011)

ⁱⁱⁱ *Canadian Association of Physician Assistants Scope of Practice and National Competency Profile*. http://www.capa-acam.ca/en/Scope_of_Practice_National_Competency_Profile_55 (11 October 2011)

^{iv} Younger, Patricia: *Physician Assistant Legal Handbook*, Aspen Health Law Centre (1997); page 73 ISBN 0-8342-0925-x

^v Competition Bureau. *Self-regulated professions: Balancing competition and regulation*. 2007
[http://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/vwapj/Professions%20study%20final%20E.pdf/\\$FILE/Professions%20study%20final%20E.pdf](http://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/vwapj/Professions%20study%20final%20E.pdf/$FILE/Professions%20study%20final%20E.pdf) (11 October 2011)

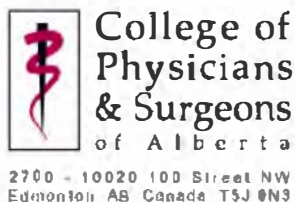
^{vi} Canadian Nurses Association. *Literature Review of Nurse Practitioner Legislation and Regulation*. 17 January 2005
http://www.cna-nurses.ca/CNA/documents/pdf/publications/cnpi/tech-report/section2/02_LegReg_AppendixA.pdf, (11 October 2011)

^{vii} New York State Assembly Bill No. S04998 (27 April 2009)
http://assembly.state.ny.us/leg/?default_fld=&bn=S04998&Summary=Y&Actions=Y&Votes=Y&Memo=Y&Text=Y (11 May 2010)

^{viii} American Medical Association. (1998). *Ratio of Physicians to Physician Extenders (H-35.975)*. *Compendium of AMA Policy*. Chicago, IL.

^{ix} American College of Emergency Physicians. (2007). *Guidelines regarding the role of physician assistants and nurse practitioners in the emergency department*. <http://www.acep.org/practres.aspx?id=29492> (11 October 2011)

^x Society of Hospital Medicine. (2004). *SHM policy statements on physician assistants and nurse practitioners in hospital medicine*
http://www.hospitalmedicine.org/AM/Template.cfm?Section=Where_We_Stand&Template=/CM/HTMLDisplay.cfm&ContentID=27816 (11 October 2011)



Bylaw Non Regulated Members

Bylaw pertaining to the registration of Physician Assistants as non-regulated members, passed by Council 03 December 2010.

24 Non Regulated Members

- (4) The Physician Assistant register includes the names of non-regulated members who are:
- A. A graduate of a Physician Assistant training program meeting one of the following criteria:
 - i. provided through the Canadian Forces Medical Services School,
 - ii. accredited by the Canadian Medical Association Conjoint Accreditation Process in Canada, or
 - iii. Accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States of America, and
 - B. A certified Physician Assistant with one of the following credentials:
 - i. Canadian Certified Physician Assistant (CCPA), granted by the Physician Assistants Certification Council of the Canadian Association of Physician Assistants, or
 - ii. Physician Assistant – Certified (PA-C), granted by the National Commission on Certification of Physician Assistants in the United States of America.
- (5) Each applicant for registration as a Physician Assistant must:
- A. complete the application form to the satisfaction of the Registrar, and
 - B. submit the registration fee.
- (6) A Physician Assistant shall only work under the supervision of a regulated member on the General Register or the Provisional Register Conditional Practice, and that regulated member will take responsibility for the clinical performance of the Physician Assistant.
- (7) If the Registrar determines that a Physician Assistant has not paid the registration fee or an annual fee, has not worked only under the supervision of a regulated member, has provided incomplete or inaccurate information to the Registrar or no longer qualifies for registration as a Physician Assistant, the Registrar may cancel the registration of the Physician Assistant.
- (8) If the Registrar cancels the registration of a Physician Assistant under subsection (7), the Registrar may publish the information as the Registrar determines is required in the circumstances.



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Requirements for Physician Assistant Registration in Manitoba

The information below summarizes the eligibility requirements and application process for registration as a Physician Assistant in the Province of Manitoba. In any disagreement between this information and the wording of the Medical Act and Regulation thereunder, or any other legislation governing these matters, the terms of the legislation will prevail.

REGISTRATION REQUIREMENTS:

The applicant must have completed clinical training acceptable to the Council, and in addition must

- (a)(i) be a graduate from a Physician Assistant training program approved by the American Medical Association Committee on Allied Health Education and Accreditation or the Commission on Accreditation for Allied Health Education Programs, and
- (ii) have passed the examination given by the National Commission for the Certification of Physician Assistants (NCCPA),
- (b) be a graduate of the Physician Assistant Program, University of Manitoba; or
- (c) be a graduate of another clinical assistant program acceptable to the council.

THE APPLICATION PROCESS:

Applications are processed in date order received. The application process usually takes four to six weeks from the date we receive your application until we have obtained all required documentation needed for registration. After your application is reviewed, you will be sent a letter outlining items still needed to complete your file. Applications are valid for six months from the date received. In order to complete your application, the following must be submitted:

1. Completed application form and \$275 documentation fee
2. Evidence of identity (certified copy of Canadian citizenship, permanent resident status, or passport)
3. Name change documentation (if applicable)
4. Criminal record check (forms enclosed)
5. Verification of medically related registration and licensure including Evidence of Good Standing from any and all jurisdictions in which the applicant has been registered or licensed. Do not return the verification with the application (see Verification of Medically Related Licence).
6. Verification of, and references for, medically related employment. (The College will contact your employers. Please ensure that you include complete mailing addresses and contact names.)

US Physician Assistant Training Program

- ✓ A letter from the Dean of PA program, including evidence of clinical training,
- ✓ A certified copy of PA diploma, and
- ✓ Verification of NCCPA certification

Graduate of Clinical Assistant Program Acceptable to the Council

- ✓ Canadian Armed Forces Physician Assistant Papers including evidence of clinical training
- ✓ University of Manitoba Physician Assistant Program diploma including evidence of clinical training.

Additional documentation as may be requested by the College.

CONTRACT OF SUPERVISION/PRACTICE DESCRIPTIONS:

In Manitoba, licensed Physician Assistants are required to work under a supervising physician. A Contract of Supervision outlining the Physician Assistant's scope of practice with regards to physician supervision, duties/procedures to be performed by the Physician Assistant, prescription and other special privileges requested, and practice location(s), must be submitted and approved by Council. Licensed Physician Assistants who do not have a supervising physician are not permitted to practice and their licence status is considered "inactive".

Registration (\$300) and licence (\$300) fees are also due prior to registration and licensure being issued (fees subject to change without notice).

COLLEGE OF PHYSICIANS AND SURGEONS OF NEW BRUNSWICK

Regulation #14

Physician Assistants

1. For all purposes under the *Act* and Regulations an applicant is eligible for registration on the Physician Assistants Register and licensure to practise if
 - a) certified by the Physician Assistants Certification Council of the Canadian Association of Physician Assistants;
 - b) certified by the National Commission on Certification of Physician Assistants;
 - c) a graduate of another Physician Assistant training program acceptable to Council.
2. Physician Assistants shall only practise in the direct employment of a Regional Health Authority unless specifically authorized by Council.
3. A Physician Assistant shall only practise under the supervision of an identified physician or physicians in a structured format acceptable to Council.
4. A Physician Assistant shall only practise within the scope of their training and recent experience.
5. A supervising physician shall only delegate or authorize a Physician Assistant to practise within the scope of the physician's training or recent experience.
6. For greater certainty, as associate members of the College, Physician Assistants are subject to all such provisions of the *Medical Act* and Regulations as may be applicable.

Adopted 1/10

<http://www.cpsnb.org/english/Regulations/regulation-14.htm>

Appendix D

CMA Physician Assistant (PA) Board Working Group Working Group Terms of Reference

Purpose:

To provide guidance and oversight to CMA activity focused on the evolution of Physician Assistants in the Canadian health care system. The CMA Board of Directors identified a need for action to advance the integration of Physician Assistants into civilian health care with the goal of improving access, reducing wait times and enhancing patient/provider satisfaction.

Reporting:

The PA Board Working Group will report to the CMA Board of Directors.

Deliverables:

Phase 1 (2008-2009) - completed

The Board Working Group:

- Provided guidance on the overall direction of PA policy development and activity at CMA
- Developed a PA informational document (the PA Toolkit)
- Developed an action plan to assist the advancement of PAs into civilian health care in Canada.

Phase 2 (2010) - completed

The Board Working Group:

- Disseminated the PA Toolkit
- Advocated for suitable funding models
- Advocated for PA regulation by medical regulatory colleges
- Continued to support CAPA and to advance the PA profession in an ongoing capacity.

Phase 3 (2011)

The Board Working Group will:

- Update and promote the PA Toolkit
- Host a 1-day invitational summit on funding models by Fall 2011
- Prepare a white paper on funding models for consideration by governments

Proposed Membership:

3-4 Board Representatives

Dr. Deborah Hellyer (renewed)

Dr. Graham White (renewed)

Dr. Susan King (renewed)

1 Committee on Education & Professional Development Rep

External Experts as required

Dr. Lyle Mittelsteadt, Alberta Medical Association (renewed)

Dr. Bill Hnydyk, Alberta Medical Association (renewed)

Ms. Carol Jacobson, Ontario Medical Association (renewed)

Mr. Ian Jones, Canadian Association of Physician Assistants (renewed)

Dr. Garth Campbell, Society of Rural Physicians of Canada (renewed)

*Dr. Terry Sosnowski (renewed)*Term:
Start: January 2011
End: December 2011

Budget:
\$51,000

Meetings:
1 or 2 face-to-face meetings and 4-6 teleconferences

Physician Assistant Implementation Steering Committee

TERMS OF REFERENCE

Mandate

The Physician Assistant Implementation Steering Committee will collaboratively guide the coordinated development, implementation and evaluation of projects to integrate Physician Assistants (PAs) in Ontario's health care system.

Responsibilities

- Develop framework, tools and information required for introduction of PAs into Ontario
- Ensure balanced provincial perspective in PA role development projects
- Maximize sharing and coordination of information and activities
- Provide advice to PA working group project leads, government, and others
- Identify and resolve issues
- Oversee evaluation of PA initiative
- Provide advice on future direction of PA role
- Guide projects to ensure deliverables are met within established timeframe

Governance Structure

The Implementation Steering Committee will establish subcommittees to guide the following projects:

- Demonstration Projects (hospital settings, Community Health Centre settings, Physician Employed Diabetes and Long-Term Care settings, Family Health Teams)
- Competencies & assessment/education requirements (Canadian PA certification, assessment of PAs for demonstration projects, post secondary education programs)
- Evaluation (performance measures, analysis, synthesis)
- A Compensation and Liability Task Force was established jointly by the Implementation Steering Committee and the PHRC
- Communications Working Group

Committee Support

The Implementation Steering Committee and its subcommittees are supported by a secretariat.

The secretariat activities will include:

- set up and communication of meetings
- co-ordination and analysis of data and other information
- preparation of minutes
- preparation of reports

Co-Chairs

The Implementation Steering Committee will have co-chairs who will be responsible for guiding and facilitating the work of the Steering Committee and the overall project.

Co-Chair (Ministry appointee – *Dr. Peter Walker*)

Co-Chair (OMA appointee – *Dr. Deborah Hellyer*)

Membership

Representatives will include employers, educators, regulators, professionals, Local Health Integration Networks, subcommittee leads, and government.

- Physician Assistant (Can) - *John Shea*
- Physician Assistant (US) - *Red Hooker*
- Employer – Canadian Forces – *Capt (N) Jung*
- Employer – Community Hospital– *Marla Fryers*
- Employer – Teaching Hospital – *Dr. Gillian Kernaghan*
- Local Health Integration Network – *Sandra Hanmer*
- College of Physicians and Surgeons of Ontario - *Dr. Rocco Gerace*
- NPA Board Member – *Tina Chrosteki*
- Ontario Medical Association – *Carol Jacobson*
- Ontario Medical Association Nominee – *Dr. Tracy Wilson*
- Ontario Ministry of Training Colleges and Universities - *Lesley Langdon*
- Ontario Ministry of Health and Long-Term Care - *Jeff Goodyear*
- Assessment and Education Subcommittee Chair – *Dr. Nadia Mikhael*
- Ontario Hospital Association – *Greg Shaw*
- Association of Ontario Health Centres – *Adrianna Tetley*
- Family Health Teams – *Fernando Tavares*
- Demonstration Projects Subcommittee Chair – *Marla Fryers*
- Evaluation Subcommittee Chair - *Dr. Rocco Gerace*
- Compensation and Liability Task Force Co- Chair – *Laurence Colman*
- Compensation and Liability Task Force Co-Chair – *Garry Salisbury*
- Nursing Secretariat – *Jennifer Yoon*
- College of Nurses of Ontario -

Term

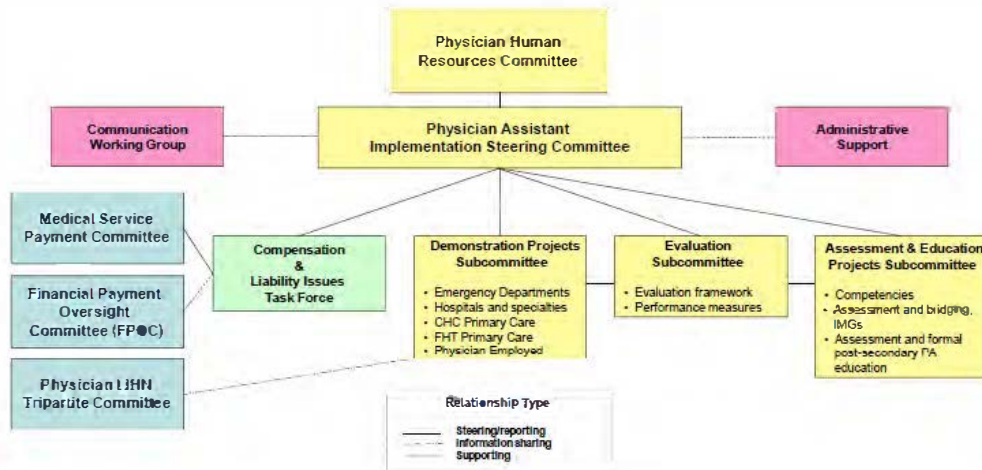
The original term of membership was two years beginning January 2007, but will be extended for an additional two years.

Meetings

Meetings are expected to be monthly for the first 6-9 months and bi-monthly thereafter.

Reporting Relationship

The Implementation Committee will report to the OMA-MOHLTC Physician Human Resources Committee.



Background information for members and potential members of the Committee on Conjoint Accreditation

This document provides basic background information for members and potential members of the Committee on Conjoint Accreditation ("CCA").

The Canadian Medical Association

The Canadian Medical Association (CMA), the voice of organized medicine in Canada, is a voluntary, national association of individual member physicians representing the majority of physicians in Canada.

CMA mission statement

To serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

CMA vision statement

A healthy population and a vibrant medical profession.

The conjoint accreditation process

The CMA is the corporate entity under which the conjoint accreditation process operates. The CMA Board of Directors ("CMA Board") is ultimately responsible for the process.

Conjoint accreditation mission statement

Conjoint accreditation is a process designed to ensure national standards for educational programs in designated health science professions, thereby contributing to the competency of graduates and the quality of patient care in Canada.

Accreditation is the public recognition that an educational program has met national standards. The goal is to ensure that programs enable their students to acquire the knowledge, skills and attitudes to function as competent health practitioners for the benefit of all Canadians.

The conjoint accreditation process brings together over forty professional organizations ("accreditation sponsors") for the purpose of accrediting educational programs in designated health science professions. The CMA provides the administrative centre and the staff to co-ordinate accreditation activities; these are referred to as "CMA Conjoint Accreditation Services".

Accreditation committee structure (see Appendix I)

Two committees are responsible for the ongoing governance and operation of conjoint accreditation:

- The Committee on Conjoint Accreditation (CCA) governs the conjoint accreditation process on behalf of the CMA Board.
- The Committee on Program Accreditation (COPA) accredits programs that meet the requirements for accreditation. Survey teams conduct program assessments on behalf of COPA; each survey team is composed of a physician/scientist, one or two health practitioners and an educator.

Accreditation sponsors are national professional organizations or provincial regulatory bodies that agree formally to participate in the conjoint accreditation process and contribute financially to the operating costs of the accreditation committees. Accreditation sponsor groups include professional societies of physicians, practitioners, educators and employers. Accreditation sponsors appoint representatives to participate in the accreditation process and cover the expenses of their representatives to attend the annual meetings.

The General Assembly of Accreditation Sponsors (“General Assembly”) is the assembly of national and provincial accreditation sponsors; it meets on an ad hoc basis to provide input to CCA on accreditation issues of general importance.

The Assembly of Health Science Professions (AHSP) includes all national certification bodies for the health science professions, and provincial regulatory bodies that have agreements with CMA. The AHSP meets twice per year to provide input to CCA on accreditation policy issues.

Surveyors are volunteer physicians, practitioners and educators who conduct accreditation surveys on behalf of CMA. The surveyor rosters constitute the pool of candidates from which the members of CCA and COPA are nominated by an Ad Hoc Nominating Group consisting of retiring members of CCA and COPA. The CMA Board appoints CCA members; CCA appoints COPA members.

Committee on Conjoint Accreditation

The CCA governs the accreditation process on an ongoing basis and reports to the CMA Board of Directors.

Mandate

- Develops accreditation policy, program accreditation requirements and assessment procedures, in consultation with the AHSP and the governing bodies of accreditation sponsors as required, for approval by the CMA Board.
- Considers health science professions for inclusion in the accreditation process in consultation with stakeholders and submits a recommendation to the CMA Board.
- Appoints the members of COPA.
- Ensures that COPA follows the documented procedures for program accreditation.
- Functions as the appeal body for program accreditation.
- Reviews proposals for annual program accreditation fees for submission with the annual operating budget to the CMA Committee on Finance and Board.
- Makes recommendations to CMA for contractual arrangements with provincial regulatory bodies and others as required.
- Reviews the governance of the conjoint accreditation process, in consultation with the AHSP and the governing bodies of accreditation sponsors, as required, and submits recommendations to the CMA Board.
- Reports to the CMA Board.

Membership

- Two physicians who hold current professional credentials, are licensed (if applicable) or have held current credentials or been licensed within the past 3 years, and who have knowledge of CMA and its strategic priorities, knowledge of accreditation and of the designated health science professions, and experience as a surveyor.
- Three practitioners who hold current credentials and are employed or have been employed within the past 3 years in the designated health science professions and who have expertise or experience in the education of health science professionals, and experience as a surveyor (one practitioner to be chair of the AHSP).
- Two educators with experience or expertise gained within the past 3 years in the education of health science professionals, one with experience in educational administration, and both with experience as a surveyor.
- One physician/scientist who holds current professional credentials, is licensed (if applicable) or who has held current credentials or been licensed within the past 3 years, and who has knowledge of the education of health science professionals and experience as a surveyor.

- Two employers (where possible, one public sector, one private sector) with senior experience within the past 3 years in health care administration, knowledge of the designated health science professions and understanding of human resource issues.
- One public representative with experience or knowledge in health professions' issues, awareness or knowledge of current consumer issues in health care and/or education.
- Chair of COPA.
- One CMA Board member (non-voting) with knowledge of the designated health science professions.

Term Up to 3 years, renewable for one term (see nomination guidelines below).
Term begins when member assumes position, regardless of whether member is filling a position vacated mid-term.

Nomination Candidates for membership are nominated from the surveyor roster by the Ad hoc nominating group. COPA members are eligible for nomination to CCA following their first 3-year term on COPA. The nomination process will ensure a representative mix of disciplines and new members while ensuring continuity through renewal of at least 2/3 of the membership.

Appointment Members are appointed by the CMA Board.

Chair and vice-chair The chair and vice-chair are elected by the committee from its membership. A candidate for chair of CCA must have been a CCA member for at least 2 years and have completed at least one accreditation survey. A candidate for vice-chair of CCA must have been a CCA member for at least 1 year and have completed at least one accreditation survey.
The minimum term of chair is 3 years from the time of election; candidates for the chair position must meet the stated eligibility criteria for CCA membership for the full 3-year term of chair to be eligible for nomination as chair. A member's second 3-year term of membership on the committee can be extended, if necessary, to fulfil the 3-year term as chair.

Meetings One face-to-face meeting/year, agenda and date to be approved by the chair; other meetings by teleconference as directed by the chair.

Responsibilities of members

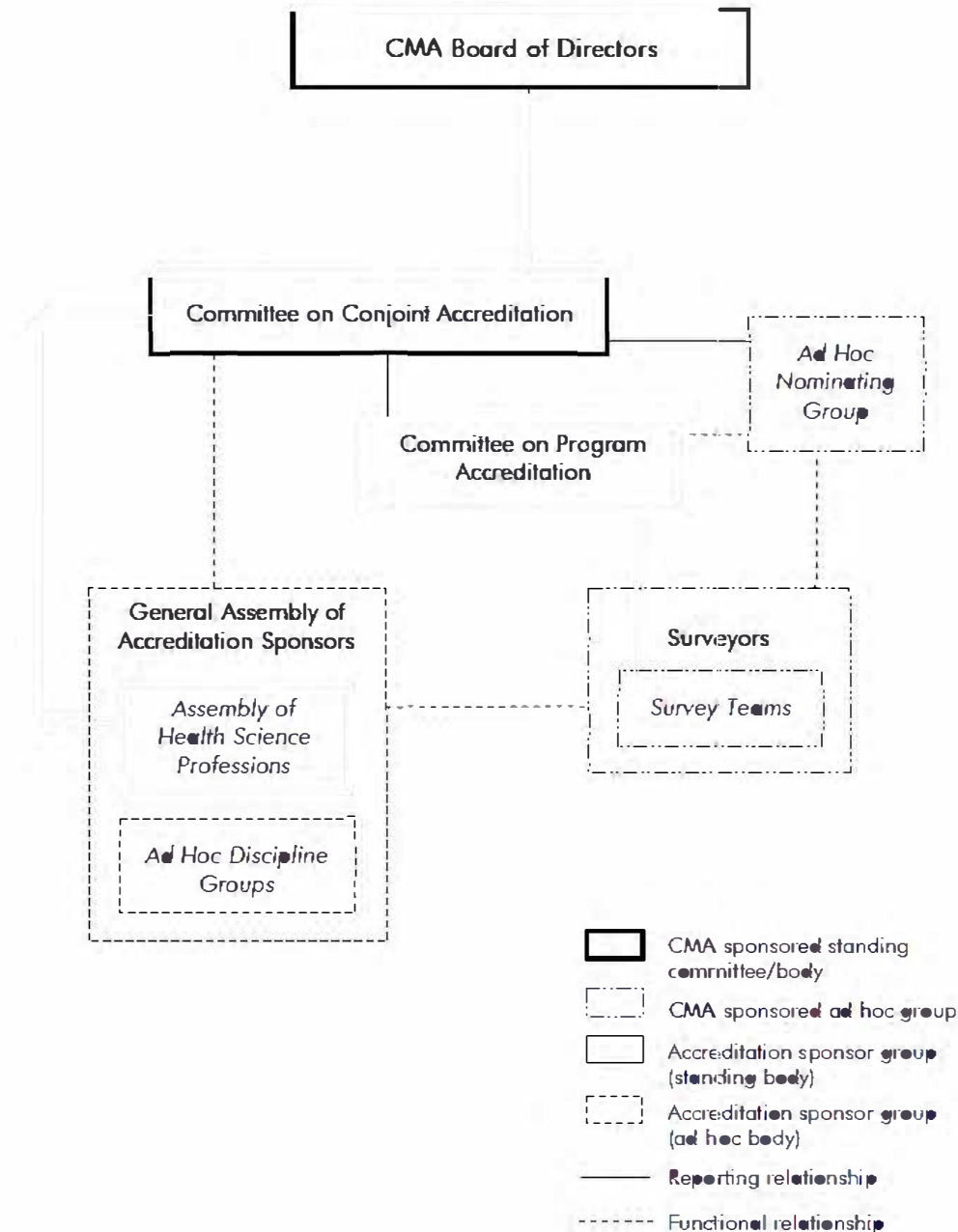
- Carry out committee duties in the best interests of CMA and the conjoint accreditation process.
- Declare any actual or perceived conflict of interest with any issue before the committee.
- Comply with all confidentiality policies and guidelines.
- Participate actively in all committee meetings and document reviews (*NB: all committee business is conducted by e-mail and secure internet site*).
- Participate in at least two accreditation surveys either as a surveyor or observer before or by the end of the first year of membership (one survey for employer and public representatives; survey is optional for CMA Board member).

Responsibilities of chair and vice-chair

- The chair will preside over all meetings of the committee, will approve the date and agenda for committee meetings, and will provide direction to the accreditation secretariat, as required, in addressing committee issues between meetings.
- The vice-chair will carry out the responsibilities of the chair in situations where the incumbent chair is unable to fulfill these functions.

Appendix 1

Accreditation Committee Structure



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Last updated 2 March 2011

Appendix E

Ministry of Health and Long-Term Care

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Dear Friends,

Warm greetings to all those celebrating National Physician Assistant Day in Canada.

Physician assistants play a crucial and significant role in Ontario's health care system. This day is a wonderful way to celebrate and recognize the tremendous contribution physician assistants make to our province. You make an incredible difference in the lives of Ontario patients each day.

Together, you ensure patients receive compassionate, timely and quality care. Through a collaborative and patient-centred approach, physician assistants are improving health care in Ontario.

I want to thank you for your dedication and hard work and I wish you all an enjoyable day!

Sincerely,

Deb Matthews
Minister

Health Professions Regulatory Advisory Council
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