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Chair

Mr. Ben Lobb

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● (0845)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Let's get the meeting started. Good morning, ladies and gentlemen. Welcome. Thank you for appearing this morning.

We're continuing our study. We have four great witnesses here to give us some insight into what we're studying.

I'd like to welcome Mr. Gravelle. He's a new member to our committee.

Welcome, sir. You can give us your perspective from northern Ontario.

We'll start with Ms. Moineau and move right across the table. Once statements have been completed, we'll have two rounds of questions, a seven-minute round and a five-minute round of questions.

I think the clerk or the analyst has probably told you that the length of the presentation should be around 10 minutes. As always, we say just try to pace it so that the interpreters can put it into the language they need to put it into.

Go ahead, Ms. Moineau.

Dr. Geneviève Moineau (President and Chief Executive Officer, Association of Faculties of Medicine of Canada): Thank you very much, Mr. Chair. It's a pleasure to be here today.

[*Translation*]

My name is Geneviève Moineau, and I am here on behalf of the Association of Faculties of Medicine of Canada.

[*English*]

Our Association of Faculties of Medicine of Canada is the representative of academic medicine in Canada. As the association of our 17 faculties of medicine, we support and facilitate collaboration within our 17 faculties relating to their mandates of health research, medical education, and clinical care, always with a focus on social accountability.

We see ourselves as uniquely positioned to help support and facilitate any work that is done at a federal and pan-Canadian level. As the academic partnership of our faculties of medicine, we provide collective leadership, expertise, and advocacy, with the goal of achieving excellence in education, research, and care for the health of all Canadians.

Our strategic goals are thus: to support our faculties, their faculty members, their staff, and our learners, the medical students and residents; to be a leading national advocate for knowledge regarding academic medicine; to support collaborative initiatives that achieve excellence and innovation in academic medicine; and to integrate all of this for the better health of all Canadians.

We feel strongly about the academic mandate as it relates to social accountability. Again, that is a founding principle of our association.

I have the privilege of practising pediatric emergency medicine.

[*Translation*]

I work in the emergency room at the Children's Hospital of Eastern Ontario, CHEO.

[*English*]

So I have the privilege of working hand in hand, in caring for our most acutely ill children, with all the appropriate health care professionals. The concept of “scope of practice” is something I live day to day in my practice, which I can truly support not only as a leader within the association but as a health care provider as well.

In our work at the association, we really understand, within our mandate to support health research, that our faculties of medicine are the hub of the places where health research is practised and performed. We are a great stimulator of all economic aspects of research as it relates to health. We are the association that oversees accreditation of our medical schools and of continuing medical education with many of the partners who are here at the table with me today as well as with the Canadian Medical Association and

● (0850)

[*Translation*]

the Collège des médecins du Québec.

[*English*]

It is of note that all of our accreditation work is done at a national level. It is a set of standards and processes that are always done throughout the country. Here is another example in which, although it is supported and funded provincially, we see health truly as a national endeavour.

On the education front, many of you will be aware of the important projects that AFMC has led, our future of medical education in Canada projects. The first is the MD project, in which you will see in the notes provided to you that there were 10 important recommendations that are currently under way.

I would like particularly to note recommendation number 8, to advance inter- and intra-professional practice.

The Chair: On a point of order, Mr. Wilks....

Mr. David Wilks (Kootenay—Columbia, CPC): The witness said that we have the deck that she's providing, and we don't have that. We have the HESA background, that's it.

Ms. Libby Davies (Vancouver East, NDP): I have a brief.

The Chair: Okay, just hang tight here for a second, Mr. Wilks.

Mr. David Wilks: I'm sorry about that.

The Chair: It looks like some people have your presentation and some don't.

Who doesn't have a presentation? Does everybody have one? Okay.

Ms. Fry, do you have one?

Hon. Hedy Fry (Vancouver Centre, Lib.): I have one, thank you.

The Chair: Okay.

Carry on. That doesn't cut into your time, just so you know. That cuts into Mr. Wilks' time.

Don't worry, I'm just kidding.

Dr. Geneviève Moineau: Thank you so much.

I was speaking to our future of medical education in Canada MD project, for which the eighth recommendation is to advance inter- and intra-professional practice. We have been implementing these recommendations—and this is an ongoing endeavour within our association—as they relate to our faculties.

The next project was on the future of medical education as it relates to postgraduate or residency education. Thanks to the generous support of Health Canada and in collaboration with our colleges, we came up with 10 recommendations, of which the first is to ensure the right mix, distribution, and number of physicians to meet societal needs. We see again within it the important consideration of potential changes in scope of practice, again to meet societal needs. One of the guiding principles of that project was to value, model, and integrate interprofessionalism and intra-professionalism into residency learning and practice. We feel that we are well on our way to integrating these concepts for both MD and residency education.

What is missing here, though, is a strategy for the physician in practice. We are looking to launch our future of medical education as it relates to continuing professional development. I see this as an area in which we can hopefully work together.

AFMC is addressing the scope of practice and skills training of health professionals in many ways. One that I want to highlight is that we have been asked to co-chair the physician resource planning task force, which is a task force that has been established by the committee for health work force at the request of the conference of deputy ministers of health.

The mandate is threefold. One is to develop a process of collaboration and coordination that addresses the imbalance in current physician supply and demand. The next is to lead the development of the pan-Canadian tool to better inform concerning physician supply as well as societal demand. The third is to create some relevant products that will help to provide accurate information to support decision-making by all of those who are considering a career in medicine, those who are in medical school in Canada, and those Canadians who are studying medicine outside of Canada, as well as those who are making decisions regarding residency choice and practice.

The AFMC is actually one of the leaders in the development of a career counselling data set that we hope will help those who have to be making decisions and those who are counselling those making decisions with regard to their future careers in medicine.

The AFMC really has a unique perspective here, because we are those who determine the future of our profession, in that we make decisions on admissions as well as the training of medical students and residents. Also, we are those who retrain members who are currently in practice and perhaps need retraining because of needs of remediation or a change in scope of practice.

Of course, all of this is done with the goal of improving patient care, and thus the recommendation of our association is that we see the federal government is uniquely positioned to take steps to become, in an ongoing manner, the facilitator of the alignment of those professions that are currently regulated, and to attempt to improve the regulation of the scope of practice across the provinces and territories.

We see that the federal government, based on the best evidence—we need to have as much data as we can to help inform our decisions—supports the increase of scope and practice in regulated health professions as appropriate, and again, depending on the practice environment, with the support and supervision of other members of the health care team, including physicians, to provide effective and efficient patient care. By efficient patient care I mean the right care to the right patient by the right regulated practitioner.

● (0855)

The final recommendation is that the federal government support the development of a national consultation on continuing professional development for physicians, with a focus of improved, patient-centred, interprofessional, team-based care.

Again, as a practitioner myself, as someone who has the opportunity of practising...every shift in the emergency occurs in an interprofessional practice mode. The importance of the nurse, of the paramedic, of the social worker, of the pharmacist, and the importance of that work happening in a team-based, patient-centred manner cannot be overemphasized.

As someone who is involved in the care of my elderly mother, who is currently in a long-term care facility, I again appreciate the importance of appropriate scope of practice, and potentially increased scope of practice for health care providers outside of medicine. Our faculties support this completely, and we hope to be a source of information in an ongoing dialogue with you on this matter.

Thank you.

The Chair: Thank you very much.

Thank you, on behalf of the committee, for taking time out of your busy day.

Next up we have Ms. Lemire, for 10 minutes, please.

Dr. Francine Lemire (Executive Director and Chief Executive Officer, College of Family Physicians of Canada): Thank you very much, Mr. Lobb. Good morning, members of the Standing Committee on Health.

I am a family physician. I practised in Corner Brook, Newfoundland, for almost a quarter of a century and worked for the College of Family Physicians for the last 10 years before becoming executive director and CEO at the beginning of last year.

I am privileged to be with you today, and I want to thank you for the invitation. My remarks will provide an overview of current best practices and the potential for federal government contributions related to scopes of practice of family doctors in Canada.

The College of Family Physicians of Canada, CFPC, is the voice of family medicine in Canada. We represent over 30,000 family doctors. We advocate on behalf of our members to ensure the delivery of high-quality health care. Our mandate in the area of education is to establish standards for the training, certification, and maintenance of certification of family physicians and to accredit the postgraduate family medicine training programs in Canada's 17 medical schools.

The mix and complexity of services provided to patients within the scope of family medicine is crucial to Canada's health care system. We are the point of first contact or the backbone of providing primary care and sometimes secondary care to Canadians. Everyone in Canada should have a family doctor to provide continuous, lifelong care in family practices, emergency departments, hospital wards, and patient's homes in every community in Canada.

The federal government has a role in supporting innovative primary care models. It must work with provincial and territorial governments to improve team-based care. Interprofessional teams and the services they deliver must be defined by the needs of the population we serve. To do this, governments can foster collaborative team care through funding structures that support the full scope of practice of all service providers, reward team effectiveness and efficiency, and reinforce organizational accountability in relation to appropriate access and the delivery of population needs-based services.

I would caution us against parcelling out the role of providers. In order to feel cared for—and by that I mean you can think of two experiences: one experience in health care where at the end of the day you really feel that the people who were there really looked after you, and another experience in which probably the right decisions may have been made but in the end you may not necessarily have felt cared for. I want to talk about the first model.

In order to do this the role of all providers must be accepted globally. The federal government must work to ensure health care access for those who live in more remote parts of our country and to aboriginal communities. We have developed a new competency-based education model called the Triple C curriculum in which we ensure that family medicine residents get appropriate experiences to provide comprehensive care, continuity of care, and educational experiences that are centred in family medicine. We prepare our future family doctors to be socially accountable to all populations, including vulnerable populations, and rural and remote populations.

We hope that the federal government can support the CFPC patient medical home vision that by 2022 every person in Canada will not only have their own family doctor but also have a personal family physician whose practice serves as the patient's medical home. This model is a model of team-based, patient-centred model of care where health care providers work to their scope to ensure excellent care and strive for the patient's best outcome.

To me, changing population needs and scopes of practice evolve within different medical specialties and health professions. The implementation of team-based care allows health professionals such as nurse practitioners and physician assistants to work with family doctors and provide a good scope of services. Overlapping scopes of practice provide opportunities for patients to benefit from the distinct strengths of individual health professionals who are part of a team. A clear understanding of scopes of practice among team members can help guide which providers will deliver services to best meet patient needs by providing timely quality care.

We support models of practice that include enhanced roles for other professionals besides physicians to improve access to care for patients. We must ensure, however, that the expansion of scopes of practice does not compromise patient safety and quality of care.

● (0900)

For example, prescribing rights must go hand in hand with the ability to make a diagnosis and take into account a differential diagnosis, the results of investigations, and above all, the patient's perspective regarding management. In most cases, professionals granted the right to prescribe medication should do so only in settings where they are practising as part of collaborative teams, with family physicians as members of that team.

We support collaboration and not competition because we believe that collaboration is what will help in the end to deliver better, timely access to patient care.

I want to provide a few examples that demonstrate this, coming mainly from Ontario.

In London, for example, the family health team reported there an approximate 20% reduction over one year in the proportion of patients with chronic obstructive lung disease who had at least one exacerbation. In 2011, the Petawawa family health team reported a 30% improvement over one year in the proportion of diabetic patients with solid evidence of improved blood sugar control. Also in Ontario, there have been some excellent examples of collaboration between family physicians and psychiatrists in a collaborative model of care, where the psychiatrist actually comes to a family practice to really provide consultation and support to the providers of that practice, thereby enhancing access to care and quality of care in the area of psychiatric health services.

Regarding the ongoing learning of family physicians, we believe the federal government has a role. The college does provide guidance and creates standards for residency programs, so family doctors can begin practice anywhere in Canada. We know that the federal government has actually provided some targeted funding and initiatives in the area of rural and remote training. The government has aimed policies toward loan forgiveness in exchange for practising in rural communities. We would encourage us to measure the impact of those incentives on retention. We do hear of rural communities being able to recruit but having great difficulties with retention.

A pan-Canadian approach is needed to help train physicians not only in hospital settings but also in community settings where so much of that care that we all get is provided.

Once in practice, family physicians need to be supported to maintain the knowledge and skills required to meet the needs of their patients. An emerging issue that you are going to be hearing from all of us is the maintenance and enhancement of physician competence and performance. We believe the federal government can signal the importance of this issue by supporting credentialing bodies, of which we are one, in looking at this more closely, and to adopt policies that best serve the needs of all Canadians.

Rural and remote practitioners, among others, face a particularly difficult situation. Their patients need them to be knowledgeable and skilled across a very broad scope of practice while building and reinforcing this scope. This can be more difficult if one practises in rural parts of this country. The broad generalist training family doctors receive help to make family medicine one of the most nimble of medical professions. We are trained to care for you from the earliest stages of life to the end of that life.

In conclusion, we're committed to working with you, with the federal government, to ensure that family doctors continue to provide optimal primary care and sometimes secondary care, when appropriate, for everyone in Canada.

Thank you once again for inviting us to speak with you today.

● (0905)

The Chair: Thank you, Ms. Lemire.

Next up, we have Ms. Lefebvre. Go ahead, 10 minutes, please.

Dr. Fleur-Ange Lefebvre (Executive Director and Chief Executive Officer, Federation of Medical Regulatory Authorities of Canada): Thank you very much.

Mr. Chair and committee members, I thank you for the opportunity to speak to you today on the issue of scopes of practice and skills training of health care professionals.

The committee is to be congratulated for tackling this complex and difficult issue. Some of us before you today have been at this for 20 years, and we've been having this discussion for 20 years.

My name is Fleur-Ange Lefebvre, and I am the executive director and chief executive officer of the Federation of Medical Regulatory Authorities of Canada, or FMRAC. For the translators, it's one of the few organizations whose name in French is shorter

[*Translation*]

In French, it's the Fédération des ordres des médecins du Canada.

[*English*]

Unlike Dr. Moineau and Dr. Lemire, I am not a physician.

Our organization represents the 13 provincial and territorial medical regulatory authorities on both the national and international scenes. It's important to note that FMRAC itself has no regulatory authority. I must also point out that medical regulatory authorities exist in legislation. The word “authority” is not used lightly. They exercise their duty in the best interest of the public. Their role is to register and license qualified physicians and to provide oversight to ensure that physicians keep up their qualifications.

On the topic of overlapping scopes of practice, the medical regulatory authorities realize that there are in fact overlapping scopes, not only among the various health care professions but also within medicine itself. There are many different specialties and subspecialties. For example, family physicians, as Dr. Lemire has already pointed out, care for their diabetic patient, but they recognize and are expected to recognize when that patient requires the attention of another specialist.

Overlapping scopes of practice are probably unavoidable, and most likely even desirable, as long as the ultimate goal is to provide quality and timely patient care. Coordination of care is critical to eliminate duplication, and everyone needs to know their own limits. The bottom line is this. Every single health care professional who has undergone the requisite training should work to the limit of their scope of practice based on their knowledge, skill, and judgment.

On the issue of pan-Canadian standards, there are many such standards, all of which contribute to, and in fact underpin, greater interjurisdictional mobility for physicians across Canada. Higher education and professional regulation fall within the mandates of the provincial and territorial governments. Nevertheless, this country has a long and respectable, I might even say enviable, track record of developing, adopting, and implementing national or pan-Canadian standards.

In training and certification, I think we would all agree that flexibility in training warrants more attention at the moment, especially when dealing with multi-year programs like some of those in postgraduate medical education or medical residencies. We are all aware of the rather disconcerting unemployment statistics in the graduating cohort of physicians in recent years.

Others at the table this morning are better positioned to address those issues. The standards for registration and licensure, however, are the purview of the members of the Federation of Medical Regulatory Authorities of Canada. Medical regulatory authorities rely on the rigorous training and/or certification processes of the Association of Faculties of Medicine of Canada, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, and of course we mustn't forget,

● (0910)

[*Translation*]

the Collège des médecins du Québec.

[*English*]

Medical regulatory authorities also rely on the national specialty societies to develop and promulgate practice standards within their particular medical discipline. Nevertheless, it is the role of medical regulatory authorities to ensure that a physician's licence to practise medicine is based on a demonstrated ability in a given medical discipline. While the physician chooses the discipline in which to train, what a physician can do and with which patient population is tightly controlled.

For instance, as has already been referred to by Dr. Moineau, a physician in practice may not choose to change disciplines without having to demonstrate competence in that new discipline. That often involves retraining. As well, a physician may not re-enter their original discipline after a period of three years away from practice without having to demonstrate competence again. The days of obtaining your licence for life no longer exist. In fact, physicians are now required to provide satisfactory evidence of their commitment to continued competence in their practice.

In other words, they must reaffirm in a framework of professional accountability that their competence and performance are maintained in accordance with professional standards. That is our position statement on revalidation.

I want to talk to you about our standards for medical practice and medical registration in Canada. We have developed pan-Canadian standards for full and provisional licensure. Both these licences involve the physician practising as MRP, or most responsible physician. This work was in part done to ensure compliance of our members with the federal-provincial-territorial Agreement on Internal Trade. While the AIT mandates mobility for physicians with full licence, it also mandates consideration of mobility of physicians who work under provisional licence if the receiving jurisdiction can accommodate the same restrictions and the same supervision requirements on that licence. Therefore, it is never possible to discuss standards without talking about the issue of international medical graduates. Most of them, if they come in on a licence, will have a provisional licence.

We define the Canadian standard as the set of academic qualifications that automatically make an applicant eligible for full licensure in every Canadian province and territory. Details are provided in my speaking notes. I only handed these out this morning, but they'll be available. The word “eligible” is used on purpose. There are other issues that come to bear when making a decision to license. For instance, we need to check a certificate of professional conduct and we need to check fitness to practise, and by that we mean physician health issues. We have also defined in great detail the screening criteria and standards for provisional licence. These are also available upon request.

One of the issues that I was told was of interest to this committee was telemedicine. This issue presents its own challenges as not all medical regulatory authorities do the locus of accountability in the same way. Some of them view the locus of accountability as where the physician is when the services are provided. I'm talking about when the services cross jurisdictions. Some of them view the locus of accountability as where the patient is when receiving the services. We have come up with a policy, which is also available in my speaking notes, that we hope addresses these issues, but we understand that one major jurisdiction that was divergent from the others is going to look at changing that, so those are the kinds of discussions we have in the hope that we can eventually come to the same standard.

Just so you know, we define telemedicine as follows: the provision of medical expertise for the purpose of diagnosis and patient care by means of telecommunications and information technology where the patient and the provider are separated by distance. Telemedicine may include, but is not limited to, the provision of pathology, medical imaging, and patient consultative services.

I want to talk to you a little bit about practice-ready assessments. The Medical Council of Canada is not represented here, but through its national assessment collaboration it is developing pan-Canadian standards to assess international medical graduates who may qualify to practise in Canada without further training, for those who are not seeking to enter postgraduate training or residency. As the Agreement on Internal Trade mandates mobility for some physicians with provisional licensure, as I stated before, it is imperative to establish standards so that each jurisdiction may rely on the rigour of assessment elsewhere in the country, because once physicians have obtained a provisional licence in one jurisdiction, they will most likely be eligible to apply for licensure in another.

Another area that may be of interest to the committee is our policy on disclosure of professional information. It's hot off the press. It describes what will be transmitted from one medical regulatory authority to another when a physician moves across to another jurisdiction or even another country, because we're also working on the international scene. The goal is to ensure that the appropriate information is available to the receiving medical regulatory authority to make a sound decision about that physician. Information about a physician's scope of practice is included in the information transmitted.

In follow-up to our work on revalidation—and Dr. Moineau already addressed some of this—we are working with several stakeholders to develop a system of physician performance enhancement. This will be a lifelong quality improvement and assurance system that has a demonstrable, positive impact on the quality of patient care and is feasible and sustainable.

● (0915)

The physician performance enhancement system will help physicians identify their own relevant learning needs, which can be addressed through education and can help improve the quality of patient care and safety. It will encompass all of a physician's roles and competencies—for those who rely on the College of Family Physicians and the Royal College—as well as each dimension of a physician's practice, so clinical, administrative, educational, and research-based.

I'll get to our recommendations. FMRAC believes that at the heart of scope of practice discussion is the issue of health human resources. We need to consider health care professional resources, including physicians, as a national resource. The training and regulatory frameworks for physicians and others support this way of seeing things as they develop, adopt, and apply pan-Canadian standards to these processes.

The role of the federal government should be as a facilitator or convenor of all the various stakeholders as we grapple with the very complex and shifting issue of health human resources planning in Canada and for Canada.

The federal government, most likely through Health Canada, and along with the provincial and territorial governments, of course, should take the lead as follows: (a) in being the convenor, facilitator, and coordinator; (b) collecting the relevant data in a comprehensive and intelligible manner; (c) encouraging all the stakeholders to engage in this process, as, for none of us, is it our main mandate; and (d) identifying success factors and establishing an ongoing evaluation matrix.

I know this is beginning to get repetitive. It wouldn't surprise you that we all knew what each other was saying before we got here this morning.

In closing, on behalf of FMRAC and its members, the 13 provincial and territorial medical regulatory authorities of Canada, I extend our appreciation to the committee and to the Government of Canada for your interest on this issue.

Thank you, and I'll be pleased to answer any questions.

The Chair: Thank you very much.

Next up is Ms. Fréchette.

Go ahead, please.

● (0920)

Ms. Danielle Fréchette (Executive Director, Health Systems Innovation and External Relations, Royal College of Physicians and Surgeons of Canada): Mr. Chair, committee members, thank you for this committee's work on this very important topic, and the opportunity to present today.

The Royal College, as Marc Lalonde called it a number of years ago, is one of the best-kept secrets in the country. We're trying to open our kimono and share our perspectives and the expertise of our more than 40,000 members, where we support their continuing professional development and set the standards for their training in 65 medical and surgical disciplines.

We were founded by an act of Parliament in 1929, and since then we've overseen the certification of medical specialists in Canada. We also support health system innovation nationwide, and we participate in a number of pan-Canadian initiatives, such as being a member of the FMEC PG consortium, which Dr. Moineau described.

Much like the College of Family Physicians, we've also embarked on a major transformation of how we train doctors in this country. Ours is called competence by design, where we're moving away from a time-based educational system, to a more competency-based system set with milestones, which will cover medical education from residency to retirement. We're confident that this will better ensure that our future specialists are nimbler in order to meet patient health care needs, and indeed, adapt to the ever-changing health care environment that this committee is currently trying to tackle.

We know that scopes of practice of health professionals are constantly changing, including those of physicians, in response to numerous factors such as health workforce shortages, increasing patient needs, and scientific and technological discovery. We know that roles are constantly changing. It wasn't until the 1950s that nurses at what was then called the Ottawa Civic Hospital right near here could carry out tasks like taking blood pressure, giving intramuscular injections, or even administering intravenous antibiotics. Only a physician could do those things.

Because health care delivery approaches are in constant evolution, new professions are also emerging, such as physician assistants, as our interprofessional care models. As the scope of health professionals outside medicine expands to encompass a wide range of roles in varying levels of clinical judgment in the diagnosis and treatment of patients, the Royal College supports and believes they are playing an important role in patient care and helping to improve access.

While we all benefit from these new ways of doing things, we also recognize that precautions have to be in place to ensure the safety and well-being of patients, as everyone has mentioned so far. This is particularly important because there are so many different definitions in the scope, admission, educational requirements, and regulatory oversight among health care professionals in Canada.

While there are many pan-Canadian standards for medicine, as described by my colleagues today, such is not the case for many other health professions. For example, pharmacists can order and interpret lab tests in Alberta and Manitoba, but not in British Columbia and Saskatchewan. They can initiate drug therapy in Ontario and New Brunswick, but not in B.C., Prince Edward Island, and Newfoundland.

Even with the emerging physician assistant profession where there are honest efforts to establish pan-Canadian standards, the University of Manitoba offers a graduate degree, but McMaster University offers an undergraduate degree. Physician assistants are a regulated profession in Manitoba, but not in Ontario.

Better coordinated approaches to the regulation of health professions not only helps assure pan-Canadian standards for education and practice, and hopefully safer, high-quality care. The very act of regulating a profession also supports data collection that can inform quality improvement and planning.

● (0925)

The scope of practice of every health professional should always be consistent with quality skills training and education throughout the continuum of practice. So we have to be mindful of evaluating the quality of the educational programs that lead to entry to practice and throughout their continuing professional development.

The scopes of practice of all health professionals should be the subject of not only high standards of education, but we also have to have the regulatory oversight, because this is all the more important because of the mobility of the workforce across the country. We don't want a health professional trained in one jurisdiction to arrive in another jurisdiction with slightly different skill sets. It's not in the interests of patients and it just makes the system so much simpler to control.

Understanding the nature of scopes of practice will not only help us assure patient safety, but it will also help us better understand the impact on care, health outcomes, and how we plan our workforce in our health system. We've conducted some research that showed that interprofessional practice models and changing scopes of practice are having a direct impact, not only on health care delivery but the number of physicians we need in this country. Conversely, there's likely that ripple effect across other health professions. More disconcertingly, as we have seen the evolution of different health care roles, we are now seeing—and are continuing to see because our research is ongoing—that there is an increase in the unemployment and underemployment of physicians. This is not necessarily a bad thing if we can better assure that we're training the right people to do the right things.

I'll give you an example. With the introduction of anesthesia assistants, who are increasingly in demand by anesthesiologists, we can see that the number of anesthesiologists we need in the country could be reduced by half. There was a study carried out in 2010 of physician assistants working with orthopedic surgeons in an arthroplasty or joint replacement or repair clinic in Winnipeg, and PAs helped reduce wait times and increased the number of surgeries that an orthopedic surgeon could do. But we haven't translated that into a more cohesive approach to planning our services and the number of workers we need.

New roles have also been emerging among advanced practice nurses, which substitute or complement the work of physicians. Nurse practitioners not only play various roles in primary care, they're also practising in acute care settings in hospitals and they assume a wide range of roles such as providing care for acutely critically ill patients with complex conditions. Advanced practice nurses can also specialize their focus within a particular disease or medical subspecialty, such as neonatology, cardiology, psychiatry, and palliative care, among others.

Evaluation of scopes of practice should be built into appropriate territorial and provincial regulation to ensure that these changes are actually having the intended impact, such as improving care, more efficient cost-effective delivery of service, and positive patient health outcomes. But we don't know that. Sharing of knowledge and research on these and other performance measures among all of us is crucial to continued advancement of quality in Canada's health care system and the judicious use of our human and financial resources, and here, the federal government could play a role.

Building on its research about physician employment challenges, the Royal College has begun planning with other health professional organizations and researchers further research about scopes of practice in medicine and in other health professions, notably nursing. This is a large-scale endeavour and its contribution to building a body of evidence and information to inform public policy and health system planning will only accrue with proper financial support.

● (0930)

When we think of the way forward, I see unemployment among physicians, as we recently observed through our research, as symptomatic of ongoing inadequacies in health workforce planning in this country, including planning and properly educating who does what. Although there are many constructive efforts to improve our approaches to plan and regulate the workforce in Canada, gaps remain. Our research and that of others has shown that planning at the profession-specific level will only perpetuate current problems that hinder timely access of Canadians to high-quality and safe care. This also impedes, as I said earlier, letting workers work to their fullest potential.

We must not only look at the number of health care professionals and population health needs, which are usually the predominant elements in how we plan health services in the health workforce in this country. We've learned that, when planning health care delivery and its workforce, it's equally important to understand and consider the effects of interprofessional health care delivery models and the availability of resources such as OR time, but also the changing scopes of practice, and how they're educated and regulated throughout their professional life cycle.

We have a number of pockets of excellence, such as those emerging from the physician resource planning task force. We have a growing body of data and evidence and a keen interest by many to collaborate, but there's no locus to bring us together. The Royal College and so many others, if you go back to all of the submissions to this and other committees, have long hoped for a national human resources for health strategy and federal leadership to convene, facilitate, and support the gathering and analysis of data and to help with knowledge translation at a pan-Canadian level to support provincial and territorial endeavours in health and workforce planning and development. The long-standing call for a pan-Canadian or a national human resources for health institute or agency would serve to garner the benefits and strengths of the learnings, evidence, and experiences from provinces, territories, professional agencies, and researchers.

The interest of the Standing Committee on Health in scopes of practice of health professionals is heartening. We truly appreciate the opportunity to share our research findings and our recommendations on the way forward.

Merci beaucoup.

The Chair: Thank you, Ms. Fréchette.

This is the first round of questions for seven minutes.

Ms. Davies, go ahead, please.

Ms. Libby Davies: Thank you very much, Chairperson.

First of all, thank you to our presenters for coming today. We've only just started this study, so this panel is actually the first non-governmental officials that we've heard. We're kind of just getting into it and—well, I'll speak for myself—wrapping my head around it.

First of all, it's just wonderful to see such an esteemed panel of women from major organizations in the country. Thank you so much for your presentations.

I'm actually going play a little bit of a devil's advocate today. I find that some of what you say, maybe a lot of what you say, is difficult to translate into everyday reality from a patient's point of view. So that's what I really want of kind of put out there.

We have this huge issue of scope of practice, team-based practice, and patient-centred care, and I don't really get why it's not happening at a much faster pace. You represent four major bodies that are right in the centre of this discussion. You've talked about the need to have the federal role, which I absolutely support, as a catalyst, collaborator, convenor, and all of that. But describe for us, what would an ideal team-based approach look like, say in an urban community? What would it look like in a remote community? Could you describe it to us? Describe it to us in terms of a family practice, or how it is connected, then, back to an acute-care facility.

I just feel like we're not getting the picture of what it actually should look like. You've given some examples, but if we had an ideal patient-centred care, team-based approach, say here in Ottawa, what actually would it look like if I walked into that as a patient? I often feel that people get bounced around. You go to your family doctor or you go to a specialist, and they can only deal with this bit. You go to someone else, and they can deal with that bit. Then, your GP feels like they don't have the expertise, so who's taking care of you overall? I do feel like there is a gap.

I'm being a bit negative, and I'm really kind of putting it to you. I just feel like it should be better than it is, because everybody's talking about the same thing, but it's not happening, or it's happening in a very patchy way. So if you can respond to that and give us some concrete examples, it would be really helpful.

● (0935)

Dr. Francine Lemire: You're asking us to try to tell you in three minutes or less how we can fix the health care system. I won't pretend to try to do that, and I don't want to sound negative either, but certainly as a family doctor I observed an incredible increase in the complexity of the patients I looked after over a 30-year career. No longer did we see patients with one diagnosis. We'd often see people with two or three different illnesses going on at the same time, all requiring a range of services, and certainly a consequence of that complexity has been for me to say I cannot look after all this person's problems by myself. That has been one factor.

A second factor has been—and I may get tomatoes on this, not necessarily in this room—the mode of payment for physicians. In primarily a fee-for-service system, which I think over time has not favoured collaborative approaches, we're seeing some innovation in looking at alternate payments, capitation, enabling us to say the person we're seeing in front of us is important. But the population of this practice—my colleagues and I, the nurses, the social worker who comes in to help us, the pharmacist—we all have a responsibility to know who we are looking after and to look at what's happening from a population-based perspective.

The third factor has been a very slow introduction of the electronic medical record, and you cannot work effectively with other providers unless you have an electronic medical record. Paper works, but I can tell you that in this environment we need to have effective information systems that enable that practice to be connected with the hospital and other resources. That's not to say we're not responsible, but to try to explain why this is not happening at the pace you and I would like to see it happen.

Ms. Libby Davies: That's very helpful.

Dr. Francine Lemire: That diabetic patient who comes to see me probably has not only diabetes but hypertension and may be at risk for coronary heart disease, heart attack, or may already have a history of such. So the patient already presents complex needs and takes probably 10 medications. We're talking about pharmacy, drug interactions, ability of that person to pay for all those drugs, so I need the social worker because I can't deal with all that in a 15-minute visit. Those are some of the realities, and those are some of the things that make that seamlessness difficult to implement.

We have some examples of very important innovations. I didn't mention the family health teams. They're not the best things since sliced bread, but they are an attempt to really try to get at this and to say we need to be able to provide access to our patients, if not the next day by that family doctor or at least by a nurse practitioner, at least by the day after that, and if not by that person, at least by someone from that practice. There are some very good examples of innovation that we need to scale up. If we have those tools that I've just talked about, then all those providers need to be able to work together to help that diabetic person with those three chronic diseases and to try to coordinate those needs from a societal and a pharmaceutical point of view.

I'll stop here since I'm not the only one here, but those are some of the factors.

The Chair: Okay, thank you. That's a great explanation. Unfortunately we are out of time, so perhaps next time round we can expand on that.

Mr. Young, you have seven minutes.

● (0940)

Mr. Terence Young (Oakville, CPC): Thank you, Chair.

Thank you, everyone, for being here.

Dr. Lemire, why in this day and age, after talking about this for decades, do we still have doctor shortages in many parts of Canada?

Dr. Francine Lemire: Once again you're asking me to solve this problem—

Mr. Terence Young: Yes, I am. We're looking for answers.

Dr. Francine Lemire: —in three minutes or less.

Mr. Terence Young: That's correct.

Dr. Francine Lemire: The “why” is we're now catching up—

Mr. Terence Young: What should we do about it?

Dr. Francine Lemire: We need to collectively ramp up our mandate around social accountability.

Mr. Terence Young: Could you put that in plain language, please?

Dr. Francine Lemire: An example of what's happening in Quebec.... In Quebec, a decision has been made that one needs to address the distribution of physicians. So there is some regional health human resource planning.

So if I'm a resident in family medicine, at the beginning of my residency I'm looking at all those regional health human resource plans to see where there is a need for a family doctor. I start negotiating with that regional health authority because I know the needs are in certain areas and not necessarily in downtown Montreal.

Mr. Terence Young: So do they pay them more to go to these communities where doctors don't want to go?

Dr. Francine Lemire: I think there are some financial incentives, but I think the Government of Quebec has been pretty clear that physicians need to go where they are needed.

Mr. Terence Young: Sometimes they go there and then a few years later they go back to where they always wanted to be, which might be a city where there's more business or where their family lives, right?

What could we do about that?

Dr. Francine Lemire: That speaks to the importance of the role of the community around the retention of physicians.

Mr. Terence Young: Yes, but does it work?

Dr. Francine Lemire: It works a little bit. I don't think we can necessarily expect a physician to go to a rural community based on a regional plan of health human resources and stay there for 25 years.

Mr. Terence Young: I live in Oakville, Ontario. It's a wealthy community, a suburb about 40 minutes from Toronto. We have a doctor shortage in Oakville. No one seems to understand why.

Can you shed any light on that?

Dr. Francine Lemire: I don't think I can shed any light on that in a specific manner. Again, I will say that I think we owe, to some extent, a level of responsibility in trying to instill in our practitioners that practice of full scope. But also understand that other providers just as Danielle talked about...we need to better understand that mix and how we can get those people to work together.

Mr. Terence Young: Okay, a lot of people would say the pay-for-service model is a failure. We end up with churn in some doctors' offices, where you go there and there are 15 people who have the flu or a cold, and the doctor is trying to get them through. They might see 70 patients a day. That is not good health care.

How should we pay doctors so Canadians get the best quality care?

Dr. Francine Lemire: I would suggest alternate payment models that are—

Mr. Terence Young: Can you give some examples, please?

Dr. Francine Lemire: It's where you get a payment per year, per patient, that is within your panel. Your responsibility, then, as a practice, not only as a sole family doctor but as a practice is to look after that population.

Mr. Terence Young: Is that working in many places?

Dr. Francine Lemire: I just gave some examples of family health teams where there have been some improvements. I think in the U.K....

Do you want to speak to that?

Mr. Terence Young: Yes, please, go ahead.

Dr. Geneviève Moineau: That is the system in the U.K., and again every system has its risks and benefits, but that is a potentially desirable system.

Mr. Terence Young: I'll just tell a purely personal story and I'll keep it very brief.

I've now been seeing a naturopath for the last two years and I'm getting better results for my own personal situation. I'm getting better results from a naturopath, so I have to pay out of my own pocket for that. On occasion, I also see a chiropractor. I pay out of my own pocket. Well, I guess that our health care plan covers parts of it, anyway.

So I'm getting better care from doctors who don't really get the full respect of the health care system, and I'm concerned about that. Why can't people get more choices? Why does everything have to be the allopathic model, that everything's driven and controlled by allopaths?

Dr. Geneviève Moineau: May I respond to that?

● (0945)

Mr. Terence Young: Please, yes.

Dr. Geneviève Moineau: That's agreed, and I think in our recommendations there's a full recognition of the fact that physicians aren't the answer. They need to be part of the answer of providing health care. I think what would help is in fact ensuring that all health care providers are regulated. Some are regulated in some provinces, but they're not in others.

I see again there a role for the federal government to look at which health care providers are regulated and which are not. If your naturopath or other care provider is regulated, they will gain the respect. What happens if you're not regulated is that there is a significant variety in the quality of care provided.

Mr. Terence Young: Can I ask you why you choose the federal government? I'll tell you why.

The primary power the federal government has over the health care regulations—the criminal power, if you go back to our Constitution—has been interpreted somewhat broadly, but it's quite limited.

What is to prevent the provinces...? They have the Council of the Federation. They went to the drug companies; they said we're going to pay less for generic drugs. They can do things.

What's to prevent the provinces from sending a couple of people to Winnipeg, each province, and doing things on their own?

Why do you always come and say the federal government should be doing something? The federal government has very limited powers to do that. There's nothing to prevent the provinces from getting together and solving any problem, if they choose to.

Dr. Geneviève Moineau: Where we see the benefit of involving the federal government is that it helps to facilitate the provinces getting together. That's exactly the example of our physician resource planning task force. It's understanding that looking at a physician resource is only one piece of the bigger pie of the entire resource planning for health care. That really is a conversation that we need to eventually have, but you have to start somewhere. We're excited to be part of that.

Again, that is a federal-provincial-territorial endeavour, and we believe that's why it will be successful. It's helping the provinces get together in doing that work.

If I could just get back to what Ms. Davies asked earlier about the —

The Chair: No, I'm sorry.

To be fair to all the members, we can't go over the time. But perhaps Mr. Wilks or Mr. Lunney can follow up on that same train of thought when their time comes around.

Next up, Ms. Fry, you have seven minutes, please.

Hon. Hedy Fry: Thank you very much, Mr. Chair.

I want to thank everybody for coming. I'm going to echo that there are four very powerful women sitting here on a panel. That's great.

The idea of these multidisciplinary teams that we've been talking about is not a new thing. In fact, money was put into the health accord, in 2004, and was agreed on by the federal government and premiers of every province. It was to pull together that federal leadership role, etc., in the change and reform of primary care practice, looking at the team, at how it links to an acute care setting —as Libby was asking you—and how, if you work for the hospital, you will know how to take people as soon as they are ready to leave and move them into a new system.

I want to ask what happened to that. That is the first question. Why did that stall in about 2007 and nothing has happened since? The federal government put money on the table for that to happen.

The second thing is that I have noted that some provinces did a little bit of it, and there are excellent examples out there. Calgary has a great clinic. Ontario has been doing a lot of good work. I think Nova Scotia has been doing some good work on this. However, they lack the ability to move any further.

With regard to the concept of scope of practice, whenever I travel across the country and I meet with ministers of health—and it really doesn't matter what their political stripe is—they all say the same thing. They say there are three areas that we, as a Council of the Federation, cannot move on alone. One is health human resources, of course the other is pharmaceuticals, and the third one is primary care reform.

The bottom line is that since the Council of the Federation has admitted that they can't take the steps they need, I wonder if you have a plan for ensuring we get that right mix of people, and that the mix doesn't only include health care professionals but housing advocates, social workers, and even school counsellors, to link into that team?

In the absence of the federal government at the table, what are your plans to try to move this agenda forward? If we don't, we will not have efficient, effective, and timely care, and we will be wasting a lot of money on acute care beds. What are you planning to do on that?

First, what happened to the plan in 2004 for primary care reform and health human resources?

● (0950)

Ms. Danielle Fréchette: Again, we have a few minutes to answer something that would require days of conversation.

We have made much progress, and you would acknowledge that we have many pockets of excellence. I would submit that what we often do is to pull the cake out of the oven before it's fully baked. We go about with our own energies and resources, without the convening power and sustainability to move this ship called our health care system, which you can't turn on a dime. We don't have the support to systematically scale up and adapt great ideas and experiments that are happening right now in the country.

Hon. Hedy Fry: Why not?

Ms. Danielle Fréchette: It is something that requires sustained effort and we don't have anyone who has agreed to take this on as a commitment to Canadians. Those of us sitting at this table are chugging away. The research that we're doing on physician unemployment is self-funded. I do a lot of it during my holidays and weekends because I'm committed to it. My daughter, who is finishing her honours degree, read my brief and when she saw the dog's breakfast of regulation and education, she was really dismayed. She said, “Mom, this is a mess. How can this be? I hope you can convince the people around this table that our government, my government, has to do something for me”. So we are all working at it in the best way we can, but we need someone to bring us together.

To the point about there being a whole bunch of people with the flu sitting in a family physician's office, and they're churning them through, well maybe if there were interprofessional teams and a good robust electronic medical record, the family physician wouldn't just be taking care of the common flu. He'd be taking or she would be taking care of more complex issues.

Hon. Hedy Fry: Francine.

Dr. Francine Lemire: There's no magic, I don't believe, in terms of explaining what happened. I certainly do agree with what Danielle has described. The funding has helped to create some innovation and I think you refer to this yourself. There's been some incredible pockets of innovation around the country, but we need to be sustaining this and really scale it up. I would argue that in fact there is a role for federal leadership in that.

I lived for a long time in Newfoundland. I have an artificial leg and it's always been an interesting thing to me that when I was living in Quebec, all my costs related to that leg were covered. In Newfoundland, none of it was covered and in Ontario, some of it is covered. Yet if I don't have that artificial leg, I cannot make my own contribution to society.

So how come we have this variety of things in a country like Canada that overall is a rich country? I think we do need some of these standards, and we do need to try to sustain some of these efforts at innovation. Probably all of us providers, physicians, nurses, all of us, need to give up a little bit of the turf and really try to put our communities at the centre, try to see how we can really be community-centred and meet those community needs.

Dr. Fleur-Ange Lefebvre: The federal government has a significant role. For the last four years we have been harbouring under two sets of expectations. The first is the Agreement on Internal Trade. The changes to the chapter on labour mobility came into effect five years ago on April 1, 2009. These are federal-provincial-territorial agreements. They don't come out of health. They come out of labour and industry. So we have the Agreement on Internal Trade that nevertheless contains the chapter on labour mobility and includes the mobility of regulated professionals including health professionals.

The other one is the pan-Canadian framework for the assessment and recognition of foreign qualifications. These have been driving a lot of the work that we've been doing on national standards, but now there is the consequence of these agreements and these frameworks. We need to have the same locus. The discussions we had were coordinated through the federal government. That has to continue. There has to be a sustained effort to make sure that these agreements and these frameworks are not in fact resulting in unwanted and unexpected consequences. At the same time as we identify other opportunities, this discussion has to go on.

● (0955)

The Chair: Mr. Lunney, seven minutes, please....

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you very much.

Well, others have commented on the four powerful women at the beginning here. I think when I first saw you, I said, “Boy, they sent a SWAT team”. What I mean by that actually, after hearing your presentations, is that we have four very highly professional, highly qualified, and very good communicators. I think all of your presentations are very well organized and you've put a lot of thought into this, so I compliment you on that.

Can I ask about the number of physicians in Canada? I think, Francine, was it you that mentioned 30,000 family physicians? What is the total number of physicians in Canada? I think I have in my mind 88,000, something like that.

Dr. Francine Lemire: That's about right. But of course that doesn't necessarily mean that they are full-time clinicians. There lies the difficulty in terms of really understanding clearly what is a full-time equivalent in this country.

Mr. James Lunney: That's a very good observation. Is that because so many are approaching retirement? Or are there other demographic issues at play in part-time versus full-time engagement?

Dr. Francine Lemire: I'll begin the answer and hopefully I'm not being asked to solve all that in the next few minutes. We do have an important cohort of baby boomers who are at the end of their professional careers. Interestingly enough I think they remain quite engaged in clinical practice, but probably a proportion of them are actually slowing down a little bit and not necessarily working full time. That's one factor.

We do have a number of physicians who have important academic roles in teaching or research so obviously they are not full-time clinicians. Certainly with the feminization of the profession—and I am not pejorative when I say this but we still need to be realistic—new physicians entering practice in all of our specialties are entering practice very often when they are at the prime of their child-bearing years.

So the notion of a full-time equivalent I think is changing. I think that as we think about the renewal of that workforce we need to be able to recognize those factors, not to bemoan them and feel unhappy about them, but to plan for them.

For example, a family doctor working for 30 years in Corner Brook who is retiring and is being replaced by a woman family physician in the prime of her reproductive years.... We might in fact need more than one of those physicians to be able to replace the work of that physician. Then we may need not only more physicians and a bit, but we may need a family practice nurse or a nurse practitioner who can also do some of the work of that doctor.

We need and I believe we have a responsibility to also prepare our members as they are entering practice, if in fact they are women in their child-bearing years, to say if you are going to enter practice and you want to look after a population, there are a few things you need to put together. So we have work to do. Those are some of the factors. I'm not sure what my colleagues want to add to that.

Mr. James Lunney: Well, thanks. I want to pick up a couple of other issues, but I thank you for covering that for us. I think it's very interesting that we recognize those factors. Women of course obviously need to have the opportunity to fulfill their child-bearing opportunities and family issues and so on, as well as all the other issues that have been raised there.

When you talk about a team-based approach you mentioned naturopaths, chiropractors, and the issue of regulation came up. I think chiropractors have been regulated in every province across the country for many years. There are about 9,000 chiropractors and about 40% of the conditions coming into a physician's office are musculoskeletal oriented, something that chiropractors are quite well skilled in.

If we're looking at barriers to interprofessional cooperation, are there any representatives of the colleges here? Is there any interaction in the colleges encouraged or taking place where chiropractors, for example, and naturopaths—I don't want to under-represent them. There are about 1,400 to 1,600 naturopaths in the community.

I have another angle I want to talk about just briefly and the time is short. Could you comment on whether there are any promising examples of collaboration? Is there any at the education level, at least, of doctors interacting with chiropractors?

For full disclosure, I'm not here to represent the profession but I practised for 24 years as a chiropractor in two provinces.

● (1000)

Ms. Danielle Fréchette: Thank you.

We are observing a lot more collaboration with the traditional and complementary and alternative medicine world, especially when we are dealing with populations who are either indigenous or in rural remote communities.

We've actually drilled into some of the literature and a number of patients in these rural and remote communities, especially women, turn to naturopaths for care of chronic conditions because they don't have access to a primary care provider. This is a part of the workforce that we have not been factoring into our health workforce plans.

There are some models where in orthopedics, for example, you can have a partnership with a chiropractor, an occupational therapist, and a physiotherapist and that always impacts on how much care is provided and how fast care is provided to patients. That is why the work of this committee is quite important and hopefully we'll be able to muster all the resources to really get a more fulsome picture. So if there are barriers to access to a care provider who is fully qualified to offer services in their particular sphere, then we can tackle them.

Mr. James Lunney: Thank you for that, Danielle.

I want to ask the same question of you, Geneviève, because you represent the colleges. As a clinician for 24 years, I actually never had experience with a local doctor where he actually came in, observed what I did, and saw how I communicated with the patients and what we were actually doing, who wouldn't refer patients afterwards, but there's this disconnect often.

Is there any interchange happening at the college level?

Dr. Geneviève Moineau: Just for clarity, I represent the faculties of medicine of Canada, so those that do the education at the level of the MD.

In fact, absolutely; this is where, when I discussed our future of medical education in Canada project, it was very clear that one of the very important recommendations was to advance inter- and intra-professional practice. Each one of our faculties of medicine has really advanced significantly in this recommendation. There are excellent examples in every school where students are learning side by side with a variety of health professions and are exposed to practitioners during their training. The more education occurs in distributed settings, as is the case now....

We have education happening not only in the big cities, in the tertiary care hospitals, but much more in communities, in distributed medical education settings. The settings are related to campuses that have been set up in smaller communities and in the tremendous network of educational experiences that are happening in the rural and remote areas as well. That allows our students to be exposed to a variety of care providers.

I can't speak specifically to the profession of chiropractor, but as a concept, this is absolutely embraced by all of our schools.

Mr. James Lunney: Thank you for that.

The Chair: Okay, thank you.

Mr. James Lunney: Oh. I was going to ask how much time I had left.

The Chair: Well, I would be embarrassed if I told you how much time you had left.

Voices: Oh, oh!

The Chair: You owe me.

Mr. James Lunney: Let me just make this one comment, Mr. Chair.

The Chair: No, no, Mr. Lunney—

Mr. James Lunney: At St. Michael's Hospital they've been working together for many years now.

I do have a great other question—

The Chair: I'm sure you do.

Mr. James Lunney: —so I hope I get another round.

The Chair: Next up is Mr. Gravelle.

You want Mr. Morin to go next? Okay.

Go ahead, Mr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you, Mr. Chair.

I have many questions for our witnesses, but I'd like to start with a quick comment.

If you're able, I would suggest that, in the future, you give your presentations in French. In fact, the committee hears few presentations in French, less than 10%. I noticed that French speakers gave their presentations in English. Even though they were good presentations, we have to make sure that French is adequately represented during House of Commons committee meetings. So I would kindly ask that you keep that in mind for the next time.

Now, I'd like to hear how the integration of nurse practitioners in Canada is going. It's a recent and growing initiative. You are probably in the best position to give us an update on how things are coming along.

I'd also like you to tell us where things stand with physician assistants. That role is gaining considerable traction in the United States, but not in Canada, I don't think.

Could you give us a progress report on the situation?

● (1005)

Ms. Danielle Fréchette: I referred to the expanding scope of practice of nurses in a variety of areas, beyond front-line medicine. In fact, the Canadian Nurses Association now recognizes more than 20 specialties.

Why can we not coordinate the effects of that expanding scope of practice with health workforce planning efforts? They are all positive things; the curriculum is very comprehensive, with accredited training programs. But we don't have an overview of the situation, and that is why we would like the federal government to help us put all the puzzle pieces together.

As for establishing physician assistant positions, Manitoba has been offering programs since the 1990s. Students receive a master's level education. Ontario has offered programs for a few years now. The practice is growing across the country, with about 300 physician assistants right now. With a new practice developing, I thought what a perfect opportunity to do things properly, but no, everyone prefers to do it their own way.

It's a matter of mutual respect. If doctors believe that physician assistants are as well trained as they are and subject to the same stringent level of regulation they are, they will gladly work with them. The first and foremost focus of doctors is the health and safety of their patients. If, however, someone on their team has an unclear skill set or role, things will not work as well.

Dr. Geneviève Moineau: I agree with what Ms. Fréchette just said. In principle, a new profession could fix some of the problems plaguing health care. It will help us deal with the perceived lack of certain types of physicians. But the profession has to be regulated.

In a perfect world, the regulatory framework would be consistent from province to province. The federal government could play a national role and provide some assistance in that regard.

Coming back to Ms. Davies' question as to why this is all so complicated, I would say the problem is turf wars. Before everyone will work together, someone up top has to make them come together and work alongside side one another. Unfortunately, turf wars exist even within the medical community, among doctors. Today, we get along well and things go quite smoothly. Overall, things run smoothly. But help is needed in that regard.

Dr. Francine Lemire: I won't repeat everything that was said, but I would like to point out that the College of Family Physicians of Canada has formed a partnership with physician assistants. It allows them to use our platform, which we use to ensure their skills remain up to date.

We have an agreement to help foster a good relationship with them so we can gain a better understanding of what physician assistants do. In fact, the Canadian Association of Physician Assistants uses our platform.

There are some promising examples of collaboration. Things aren't moving at lightening speed, but I think we should still learn from certain initiatives that serve as positive examples going forward.

Mr. Dany Morin: I would think that your organizations welcome the expanded roles of pharmacists and nurse practitioners, who have the authority to prescribe certain types of drugs. Do you support those kinds of developments or do you have reservations about them?

● (1010)

[*English*]

The Chair: We are over time just like we were with Mr. Lunney, so perhaps we can pick it up when Mr. Gravelle has his time.

I do apologize, but I'm trying to be fair here for both sides.

Hon. Hedy Fry: This must be a chiropractic trait.

Some hon. members: Oh, oh!

The Chair: Yes, that could be.

Next up is Mr. Lizon.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Mr. Chair.

Thank you to all the witnesses for coming here this morning.

I will continue on the topic my colleague Terence Young asked you about.

I checked some statistics. We say we have a shortage of physicians in Canada. I'm representing a riding in Mississauga. It's in the GTA. It's hard for people at the present time to find a family physician. Some people are retiring. Some physicians are selling their business, and therefore there is a continuation, but some are not. Therefore, people are left looking for a family physician.

Statistics tell us that last year we had the largest number of physicians in the history of this country. How does this translate to the problem we have of a shortage of physicians to serve people?

Dr. Francine Lemire: Based on what we know, we're catching up on numbers. The area in which we're failing is distribution. That's what I see as a big problem now and in the future and something that obviously needs to be addressed collectively.

The collective is the way we prepare physicians and we have conversations with them about their social responsibility. I think some element probably needs to be enforced, using some element of regulation to make physicians understand where they are needed, as opposed to making them believe that they have full freedom to put their shingle on the street.

Mr. Wladyslaw Lizon: Yes, but at the end of the day physicians are employed by the province or provincial bodies. In Ontario most of them are—by the hospital or, if they have their own practice, they bill OHIP. How do you make them go to somewhere they are needed? You can't force people to do it. We have underserviced, remote areas and we have incentives for doctors.

I know some cases in which young doctors took advantage of the incentives and then came back because there are no schools for children offered in the same way as in larger centres.

There are other problems. Incentives are there, but that fact doesn't necessarily mean that people are going to take their offer at face value and go there and stay there.

Dr. Francine Lemire: It's multifactorial, and it relates not only to the practice of the physician but the job of his or her spouse and the other issues you've discussed. It's not an easy situation, and certainly none of us, I don't think, at this table can enforce anything with our providers. We can train them according to the best standards, we can advocate, nudge, but we certainly cannot force them.

This is an area in which there needs to be some government policies that influence those choices, there needs to be some community engagement that helps to work on retention of physicians, and there has to be some ownership by the providers themselves.

Dr. Geneviève Moineau: Thank you for the great question.

We believe, and this is part of the work we're doing through the physician resource task force, that medical students should understand from the very beginning that they have a social accountability and that they will be asked to work where the needs are greatest.

We also believe that the problem isn't so much an incorrect number of physicians but a distribution problem. I would suggest that the model that currently exists in the province of Quebec, in which new graduating physicians can only work where the government states that there will be a position, is a model you may want to look at. That, I can tell you, is really helping within that province.

Just to correct a point, the vast majority of physicians are actually self-employed, and we bill the province for services. This was part of the initial conversation about what the crux of the problem is. A physician can chose to work two half-days a week or work six days a week, at this point in time.

● (1015)

The Chair: We're over our time again, but we will probably have enough time when we're through with this round to ask some more questions, which will allow our panellists to expand on these thoughts.

Mr. Gravelle.

Mr. Claude Gravelle (Nickel Belt, NDP): Thank you, Mr. Chair. It certainly is a pleasure for me to be on this committee and at my first meeting with this health committee. I hope everything goes well.

Mr. Chair, I have two very important questions, so could you let me know when I have two minutes left, please?

My riding is in northern Ontario, and we always have a hard time attracting doctors in northern Ontario. We have now and have had for the last 10 years, maybe, the Northern Ontario School of Medicine, which is helping greatly. We certainly would like to improve that right across northern Canada.

[*Translation*]

My question pertains to community health centres.

Before becoming an MP, I was on the committee of a community health centre. Attracting doctors to work in community health centres was tough because they weren't accustomed to working in a team. Older doctors were never encouraged to work as part of a team. Younger doctors have an easier time with that.

Do other provinces have community health centres like the ones in my riding? And if so, are they regulated?

Dr. Geneviève Moineau: Different models have been established. Other provinces do have them, but they were set up differently.

You said that older doctors weren't accustomed to working under that model. And that's precisely one of the dimensions we feel is important. Doctors need ongoing education. It would be very worthwhile to study that aspect in order to help those doctors by giving them the training they need to feel comfortable working in a team.

Dr. Francine Lemire: I would add to that that the training of our doctors now and in the future must focus heavily on the importance of working as part of a team. Their training must expose them to experiences that will enhance their ability to work in a team going forward.

There is no doubt that the community health centre model is philosophically relevant in terms of meeting a community's needs. Other models exist as well. Quebec's local community service centres, or CLSCs, are really the equivalent of community health centres. The stumbling block, however, lies in the productivity.

Mr. Claude Gravelle: Thank you very much.

[*English*]

Thank you very much.

I've just been told that I have two minutes.

I worked with a doctor from England who wanted to come to Canada to practise. It took me several months to bring him. Last month I was working with a doctor from Brazil who also wants to become a Canadian citizen and practise in northern Ontario. She was successful last month in getting her Canadian citizenship. Last week I started working with a doctor from Russia.

It's difficult to get the Canadian citizenship official papers or whatever. If we could get the Minister of Immigration to fast-track these semi-qualified doctors to come to Canada, could the college of medicine fast-track the doctors? I know that from every country their qualifications are different, but if we were able to get foreign-qualified doctors, could the college of medicine help in fast-tracking their education to become qualified Canadian doctors?

● (1020)

Dr. Fleur-Ange Lefebvre: You used the word “semi-qualified”, which has alarm bells going off all over the place, for me.

Voices: Oh, oh!

Mr. Claude Gravelle: They are fully qualified in their country, but probably not qualified in Canada. They may be lacking something—

Dr. Fleur-Ange Lefebvre: Are these people who you deem require more training and would not be eligible for a licence as they stand?

Mr. Claude Gravelle: —because they haven't been trained in Canada. They haven't been educated in Canada.

Dr. Fleur-Ange Lefebvre: But some foreign-trained doctors will qualify for practice under a provisional licence.

Mr. Claude Gravelle: For example, a doctor from England did qualify, but the doctor from Brazil and the doctor from Russia—

Dr. Fleur-Ange Lefebvre: You know, we have very strong human rights legislation in Canada, and it doesn't allow us to look at some cohorts differently than others. We have to look at individuals. We have standards in place and we have what we call the selection criteria, which can be made available to the committee. This is where we say that first of all they need to demonstrate language proficiency. Citizenship and Immigration won't allow you around that, and neither will we. They have to work with patients in the right language. They have to demonstrate good standing. They have to demonstrate good character. They have to demonstrate that they are healthy. They have to take some exams that only foreign grads have to take. Then, when they get here, we will not allow someone to practise medicine under a provisional licence unless they undergo a period of observed practice in an assessment mode.

We have a limited number of slots. It's complicated, but everybody has to go through the same system.

Mr. Claude Gravelle: I think you hit the nail on the head there when you said that you had limited slots, because the doctor from Brazil, who is now a Canadian citizen, is waiting until next year to practise because there are no slots for her to practise.

Dr. Fleur-Ange Lefebvre: There are slots for practise and there are slots to enter a residency. They are two different cohorts of doctors.

The Chair: Thank you for that.

Mr. Wilks.

Mr. David Wilks: Thank you, Mr. Chair.

I'd like to thank the witnesses for being here today. I will share my time with Mr. Lunney. I just want to make a couple of comments here.

A couple of you, in my opinion, hit the nail on the head with a couple of things. One is that I think there is an opportunity to work with the medical professions to evaluate fee-for-service versus a primary health care model. In my small community in British Columbia, Sparwood, we've switched over to the primary health care model that we believe works far better than fee for service. We have three medical doctors, yet 20 minutes down the road in Fernie, which has 4,000 people, there are 18 medical doctors, most of them part time because they are there to ski. They are not there to actually ply the trade, but they can make enough money to stay there year-round. Someone mentioned social licence, and I think that's a significant issue in some areas.

Finally, I think that one of the things in British Columbia that has been an interest to watch over the years is that the province's implementation of the health authorities has been a failed project, I think. As far as I'm concerned, it's a buffer between municipalities and the province and it has become very challenging for even the medical profession to access who they need to access at the proper time.

These are a couple my comments because I wanted to allow Dr. Lunney to speak again.

Go ahead, Dr. Lunney.

Mr. James Lunney: Thank you very much, Dave.

I really appreciate that you have all been thinking about this, and you gave some examples: physician assistants, anesthesia assistants, arthroplasty assistants, and nurse practitioners. People are trying to experiment with more effective models and the team-based approach. You did put some good thought into that, and I appreciate that it's the AFMC talking about the federal government probably having a good role to play in actually monitoring different models and encouraging some experimentation, but mostly monitoring and documenting the best models because some might work better than others obviously, especially in rural areas.

Talking about urban-rural areas, I'm just a little concerned because 80% of our population is urban. All the resources are urban, and of course we have to get past that somehow to serve the rest of Canada, which is outside our big cities.

For example, and this fits in with telehealth, in British Columbia there is an innovative cancer clinic in Vancouver where they are treating patients. The oncologist is treating, and there are four GPs, and now expanded to six. They are doing some innovative work that is getting good outcomes by upping vitamin D levels, counselling and managing stress, giving them good diet and exercise, and so on. The province has expanded the program. They are reaching out through telehealth to the rural areas with high-needs patients and then connecting them so they can always get through to somebody to explain what's going on in their body. It's an innovative model.

We want to expand models like that, but this is integrated medicine in a sense.

I wanted to ask quickly about orthomolecular doctors because you have some licensing and regulating issues here with doctors who practise outside the box, and somebody recommends a licorice supplement. There's a lot of interest in the public in clinical nutrition where low-cost, low-risk things actually can give some benefits to the patients. They are interested, but we have some trouble with the regulators.

Would one of you care to comment on that? I know some of the colleges are actually interested in establishing faculties of integrated medicine since the public is interested. Why are we having trouble with the regulator?

● (1025)

Dr. Fleur-Ange Lefebvre: There is no such thing as trouble with the regulator.

Voices: Oh, oh!

Dr. Fleur-Ange Lefebvre: You want to talk about regulators dealing with out-of-the-box substances, we could, of course, go down the road of medical marijuana, but let's not do that right now.

Mr. James Lunney: I appreciate the position taken by the CMA recently.

Dr. Fleur-Ange Lefebvre: Regulators do not develop the standards of practice, on average. They rely on the specialty societies. People who do this, this is their expertise, but the regulator will say to these physicians that they need to bear in mind that the standard of practice is *x*. If they're going out of standard practice *x*, they will possibly need to tell us why.

You have to remember that it is the physician who is held accountable for the appropriate care for that individual patient at that individual time. It's a complex situation. I don't know how many subspecialties we have right now, but it's a lot. So you have to remember these patients are not your experimental pool of people.

Mr. James Lunney: I see a couple of others want to respond.

Dr. Geneviève Moineau: Again, we have probably the best medical education in the world in Canada, based on the strengths of many of the organizations represented here today. Part of that strength comes from the fact that we practise medicine as evidence-based. So the care that is provided to our patients must be the best care and must be considering patient safety.

From that perspective, before we are to be the proponents of any therapies or treatments, there needs to be the appropriate amount of evidence to show that.

Now there are times when treatments are not harmful, but again, these should not be advocated if there's no evidence that they're actually helpful.

The Chair: Thank you.

Mr. James Lunney: End of time...?

The Chair: Yes, sorry. Thank you.

Next up is Ms. Davies.

Ms. Libby Davies: Thank you.

I hope you don't feel that we're all putting you on the spot. You've actually been giving great answers. I think we recognize that, yes, there are turf wars and all of that, and territories, but you're also part of the solution.

I just wanted to pick up on my colleague Mr. Morin's question about nurse practitioners and physician assistants. I don't understand why we don't have more of them in Canada. It's better in Ontario than it is in B.C. In B.C., it's really hard.

I just want to relate a recent experience. I happened to be in the U. S. and I got a bronchial infection. I ended up going to see a doctor and I have to say I was really impressed. I'm not advocating their medical system, but in terms of the doctor's office, first of all I didn't see a doctor, I saw a nurse practitioner. They took all of my medical history and put it into the computer as I sat there with a medical assistant. So I saw two people.

As well, I never got the prescription. It was emailed directly to the pharmacy. So with the issue of abuse, I never held the prescription in my hand. It went straight to the pharmacy, so there was an electronic record. I thought, wow, this is so straightforward.

But it strikes me that in Canada, because most doctors operate in their own practice or with a number of doctors, it's up to them to decide if they want to hire a nurse practitioner, and most people don't. So how do we motivate them to avoid Mr. Young's problem, his great example of people loading up a doctor's office, when really they just need to be treated for the flu? A nurse practitioner would do the job.

It's so incredibly staring us in the face, but it doesn't happen. So how can we help motivate that to happen?

● (1030)

Ms. Danielle Fréchette: If I could just jump in, we have to understand that there are different types of practice settings, right? For half of the doctors in this country, they often rely on larger infrastructures, like hospitals and so on.

But I know for a fact that the Royal College, much like the College of Family Physicians, is very supportive of physician assistants. But to the point about compensation models, and physicians being in effect self-employed individuals, we talk about the size of their income, but they will often have to pay for the nurse practitioner or the physician assistant out of that income.

Ms. Libby Davies: So how do we change that, then?

Dr. Francine Lemire: We just need to scale up some of the innovation that's already existing in this country with some of the new models of care. I think certainly some of the Ontario models of care—

Ms. Libby Davies: That has to get us into the payment model though, because most doctors are choosing not to hire someone because it impacts their own salary. So is it better to have a salaried situation?

Ms. Danielle Fréchette: Again, for those physicians who are not practising independently, but functioning in a hospital setting.... Some of our very own board members at the Royal College who work in institutional settings would love to work with a physician assistant, but it's not on the books because you have to fit into a larger infrastructure.

Dr. Geneviève Moineau: In fact, in organizations where physicians are reimbursed as an alternate funding plan, so it's not a direct fee for service—all of our hospitals in Ottawa function that way, where the physicians working within the hospital settings are on an alternate funding plan—in those environments you do have the opportunity to work with physician assistants and nurse practitioners.

In the pediatric emergency department, I work side by side with a nurse practitioner and they provide fantastic care, at a much lower cost.

Ms. Libby Davies: I think I'm really speaking to what is the traditional model. You go to your individual family physician. They're their own employer, and so really, it's kind of the elephant in the room. We never talk about it.

Dr. Geneviève Moineau: There is no financial incentive there.

Ms. Libby Davies: We never talk about it. I can tell you that we talk everything else, but we never talk about the payment method in Canada. It's like people don't want to touch it, at least politically, and I feel that we have to take this on if we're going to deal with this really team-based, patient-centred model that we all talk about.

Dr. Geneviève Moineau: The other beauty of what you just described in your personal experience is this. Imagine if I as a patient owned my medical information, and that if I happen to be travelling, I have—maybe not the microchip under the skin—but maybe I have a credit card with all of my medical information on there and any time I access care, that gets put on that card. No matter where I am, no matter who I'm seeing, my entire medical information, my medications, my care providers, all of that would be available to me. That's a complete flip of what currently happens. Right now my personal records are sitting in different people's offices on paper.

The Chair: Thank you.

Mr. Young.

Mr. Terence Young: Thank you.

Madame Moineau, we've been talking about that for at least 20 years. They did it in Israel 15 years ago. There were roadblocks to that and part of it is inertia. The medical profession does not want to change. There are privacy issues. We just talk and talk about this stuff.

I want to ask all four of you, if you don't mind, for a one-minute answer to one question. I have five minutes. If you can do it in plain language we will have it as a record here, because you have your own lexicon, and I understand that....

Here's my question, if you can just give a short answer. What are the key roadblocks you can identify in scope of practice to serving patients better? Just a one-minute answer from each would be very helpful. Thank you.

● (1035)

Dr. Fleur-Ange Lefebvre: I could start you off by telling you that there's no such thing as a legal definition of a team, the last I heard from the Canadian Medical Protective Association, which means that when you need to hold these professionals accountable for an adverse event, it's complicated. We're beginning work with the National Association of Pharmacy Regulatory Authorities and the Canadian Council of Registered Nurse Regulators to implement something from task force two, which is a framework for interprofessional regulation.

It's just the beginning.

The Chair: That was 30 seconds, really good.

Ms. Danielle Fréchette: We need to have people understand each other's roles because if you don't know what I'm doing, it's kind of hard for you to work with me. You have to be confident that I'm competent, able to do the things that you think I ought to be doing, no matter where I trained or worked in the country.

Dr. Francine Lemire: We need to be able to manage the overlapping scopes of practice at the local level. This is where it works the best, and we have lots of lessons to learn from the rural environments. If you don't do it there, you die.

Dr. Geneviève Moineau: I would reiterate the fact that in order to be successful in this endeavour, there needs to be oversight that facilitates all of the players coming into a room, sitting around a table, and you lock the door and you don't let them come out until they have figured it out.

That's the turf. The other piece is that there needs to be financial incentive to move forward. Currently where it is, certain specialties who make a lot of money, family doctors who are specialists in their own right, who are relatively underpaid for that most important work, that is one of the issues. The other financial piece is that, as we described, there's no financial incentive for physicians to even think about bringing in other health professionals to provide perhaps what would be even better care for that particular patient.

Mr. Terence Young: Would you say there are perverse incentives in the system to providing better and more efficient care for our patients?

Would you care to identify some, please?

Dr. Francine Lemire: That don't support that care?

Mr. Terence Young: That undermine that care.

Dr. Francine Lemire: Yes.

Mr. Terence Young: I think you're the person who could do this best because I don't want anyone picking on the doctors. You are a doctor, so it would be very helpful if it came from you, Dr. Lemire.

Dr. Francine Lemire: I've felt quite picked on in the last hour, but that's okay, I can take it.

Voices: Oh,oh!

Dr. Francine Lemire: I will say to you what I have said elsewhere. Certainly for family medicine, in trying to increase the attraction of that discipline we have said, more or less they can do family practice, they can pursue areas of special interests, they can have flexibility in the profession. All this is true, except that now we need to deal with some of those consequences: that as a family physician, paid by society and being conferred that privilege by society, you have a responsibility to society.

For me as a family doctor, that's being able to see all men and women of any age, all presenting problems. By that I don't mean since you have chest pains, I'll send you to a cardiologist.

Provide superb follow-up, look after a defined population, and do so in more than one practice setting. That is a societal responsibility we have as family physicians, and that we need to promote. It's not a pick and choose. You can't break those five things. They are part of the core of this profession.

The Chair: Thank you.

Mr. Terence Young: Do I have more time, Chair?

The Chair: You're out of time, and we have about six minutes left. If it's okay, I'll give three minutes to Dr. Fry, and three minutes to Mr. Lizon, and then we'll wrap it up.

Hon. Hedy Fry: Thank you very much, Mr. Chair, for giving me that time.

Having been a family practitioner, I can tell you, it's difficult to hire somebody when, in an urban setting, 55% of your income goes to overhead. You don't have a lot of room to manoeuvre.

I'm going back to the mix. Currently, we have an unbalanced mix. For instance, there are too few family care physicians, and a lot of people are going directly to obstetricians, to pediatricians, to specialists for what is really primary care. That is an expensive way to deal with the system.

You mentioned, Dr. Lemire, the need for family physicians or primary care people to be paid better so they can do it. Looking at capitation models, salaried models, etc., is one way to look at it. But how do you look at a 10-year plan, say, with everybody working together saying here are the number of pediatricians they're going to be needing in 10 years, so you don't allow people to graduate, and everyone wants to go into a specialty. They can't. We don't need them. There are too many of them. Let's go to this, and let's set that.

The only people, I think, who can set that mix are the colleges of nurses, physicians, pharmacists, etc., working together to look at the appropriate mix. How do you see that happening? Can that happen without the federal government at the table?

● (1040)

Dr. Geneviève Moineau: We were just discussing it. I'll take that. That is exactly the mandate of the physician resource task force that has been commissioned by the committee on health workforce. This was based on the first recommendation of the future of medical education project: determine the right mix, number, and distribution.

All our organizations around the table are on the task force or on the technical steering committee that is looking at that question. At the end of the day, we want to be able to help inform the provinces, and remember, this is a federal-provincial-territorial activity.

Based on our data, it appears we will need fewer of these, so it comes back to the provinces appropriately allocating the number of residency positions, and in Quebec, the provincial government establishing the number of PREMs, as they call it, to say this is the number of practising physicians we will accept in our province.

We hope that type of evidence-informed planning will come out of the work of the task force.

The Chair: Okay, just to be fair—

Ms. Danielle Fréchette: But the work of the federal government isn't done because you acknowledged just a moment ago that we have advanced practice nurses. So we have a shortage of psychiatrists in the country, or at the very least a distribution problem. But advanced practice nurses in psychiatry are there. Although we're going to get the doctor number right, we need the federal government to help pull everybody together so we can actually better allocate the number of psychiatrists as we know how many advanced practice psychiatry nurses are being trained.

The Chair: Okay, Mr. Lizon.

Mr. Wladyslaw Lizon: Thank you. I'll ask two quick questions and we'll see how much time we have.

One is on the model of paying family doctors per visit versus salary-based. I think both would have pros and cons. On the salary-based, I think you may run into a problem that I'll be waiting for a visit for six or seven months because the doctor decides to see two patients a day.

The second question I have is to Madame Fréchette. You probably know that the committee just completed this study of prescription drug abuse and misuse. Many witnesses appeared and stated that one of the problems of overprescribing, drug abuse and misuse, is the lack of proper training of physicians.

Perhaps you can address both please.

Dr. Geneviève Moineau: With regard to the different models of payment, absolutely, but this is something that should be studied. I would suggest that our current payment model is not ideal and we need to look at how to improve upon the payment model.

From the point of view of the education around medication, and specifically certain restricted substances, I think that has been addressed within our medical schools. I think what needs to happen is that, again, this is the importance of the ongoing education of physicians. As everything changes so quickly in medicine, there needs to be ongoing, continuing professional development of physicians who are in practice. Certainly, one of the very helpful tools that have been developed in this area was actually developed with the support of FMRAC.

I don't know if Fleur-Ange wants to speak to that.

● (1045)

Dr. Fleur-Ange Lefebvre: Well, we can. It's so important to remember that physicians graduate with a certain skill set, and within five years we know that their chances of passing their exit exam are not very good because they've tailored their practice. So they have to demonstrate to the regulators, on an annual basis, that they keep up, that they fulfill the minimum number of CME-CPD credits that they have to, that are set by the two certifying colleges. But we're asking them to go further. Everything they do must be tailored to what they actually do with their practice population every day.

Ms. Danielle Fréchette: So to follow up on the points that have been made, a very robust electronic medical record would also help clinicians understand the breadth of things that are being fed to the patient. That would help curb some of the drug abuse, because if I'm getting opioids from three different physicians you may not know. So that would help.

Second, we also have the introduction of new things on the menu for physicians, like medical marijuana, and I think we're all consistent in our plea to say we need more systematic evidence so that the members of our organizations can prescribe this safely. Our advice to them, based on what the Canadian Medical Protective Association has advised us to do, is that if you are not comfortable with it, don't prescribe it. It's just like a pilot would not fly a plane that they're not comfortable flying.

The Chair: That was pretty good timing. We're just about 30 seconds over time.

Thank you once again for a tremendous presentation. There are other members who must get on to their next committee.

The meeting is adjourned.