Stakeholder Feedback on the Regulation of Physician Assistants under the Regulated Health Professions Act, 1991 (RHPA)

Responses from Organizations

Note:

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Health Professions Regulatory Advisory Council (HPRAC)

Ontario
Health Professions Regulatory Advisory Council
Conseil consultatif de réglementation des professions de la santé

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Respondent: Association of Ontario Midwives
1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?
Yes, the Association of Ontario Midwives believes that the current lack of a formal complaints and disciplinary process for Physician Assistants poses a risk of harm to the health and safety of the public.
2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?
Yes, if the profession continues to grow and Physician Assistants plan to become more integrated into the health care system, regulation would be in the public interest.
3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.
The applicant has not made a convincing argument that regulation under the RHPA is the only option to address the risk of harm. Alternatives to regulation could be investigated as long as they included a formal complaints and disciplinary process
4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.
It is difficult to assess whether regulation under the RHPA is appropriate for the profession since the scope of practice consists of entirely delegated acts.
5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.
Yes, it appears that regulation with the College of Physicians and Surgeons of Ontario could be practically implemented. If Physician Assistants are regulated under the CPSO, a thorough protocol should be developed for minimizing conflicts of interest and addressing conflict between physicians and physicians assistants.
6. From your perspective, does the applicant convincingly demonstrate the extent of the impact by which the regulation of Physician Assistants will have on Ontario's wider health system? You may wish to comment on such issues as inter-professional collaboration, labour mobility, access to care, health human resource productivity and health outcomes.
The Association of Ontario Midwives is concerned with how this may negatively affect the quality of care that Ontario's women and newborns will receive. Registered midwives and family physicians are the appropriate obstetrical care providers for women during low-risk pregnancy and birth; an expansion of the role of physicians assistants into low-risk obstetrics would be an inappropriate diversion of resources. The Province need not look to physician assistants to help extend the roles of physicians in maternity care; rather, they need to look to the already proven, cost-effective, high quality care that Ontario midwives provide. Across the province, midwives still struggle with obtaining hospital privileges and working to their full scope of practice. The first step in addressing any shortage of obstetrical care providers is ensuring midwives' access to hospital privileges and that the entire complement of midwives' skills are maximally utilized. Midwives have specific training in maternal and newborn care that physician assistants do not. It would be critical for patient safety and continuity of care that, in instances

where medically unnecessary transfers of care from midwives to physicians occur, physician assistants not take the place of midwives. Midwives' scope could also be expanded to well-woman care and reproductive care, including abortion, to address provider shortages for these services.

Midwives work in a continuity of care model that contributes to extremely high rates of satisfaction by midwifery clients. Within this model, midwives often continue to provide supportive care to their clients even when care has been transferred to a physician. For example, in the case of caesarian section where care has been transferred to physician, the midwife can maintain a supportive role vis-à-vis her client in the operating room. We are concerned that an expanded role for physicians assistants in labour and delivery may interfere with midwives' continuity of care with their clients.

7. Do you have any other general comments?

Association of Ontario Midwives respectfully calls on HPRAC to carefully consider the role of Physician Assistants in Ontario's health care system when making a recommendation as to the regulation of PAs under RHPA. In this time of important health care restructuring, this decision should not be taken lightly, as it has the potential to undermine the quality of maternal and newborn health care delivery in the province.

Respondent: Canadian Forces Health Services Group

1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?

Clarifying Note: Under "Organization Type", the Canadian Forces Health Services Group is part of a Government Ministry/Agency, but is also a Health Services Organization and fulfils some or (for certain occupations) all functions of a Health Professions Regulatory College within the military health context.

From the The applicant and the profession do meet the requirements of 'risk of harm'. PAs as employed within the Canadian (and US) Forces and in US states variably conduct patient interviews, order diagnostic tests including radiological imaging, order medications in accordance with medical directives (side effects/adverse effects), perform clinical procedures as delegated, including minor surgery / laceration repair, advanced trauma and cardiac life support, etc. In a military setting, they do all of these while deployed far from their overseeing physician in isolated locations such as Canadian Forces Station Alert near the North Pole, aboard Her Majesty's ships, on deployed exercises and operations within Canada or abroad, at Forward Operating Bases in Afghanistan, etc. For these reasons, PAs are carefully regulated by the Office of the Surgeon General within the military health jurisdiction. As an extension of physician services, most arguments calling for physician regulation are largely applicable to PAs.

For Canadian Forces PAs deployed within Ontario to support military exercises or in response to domestic civil emergencies at the request of the Ontario government, their regulation would facilitate collaboration with civilian health facilities in the care of Canadian Forces members and Ontario civilians. It would also facilitate their ability to maintain clinical skills at civilian facilities and to reduce clinical risk in the event that Canadian Forces medical support is requested to assist the provincial response to civil emergencies.

2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?

Yes. Regulation would establish a formal process for adjudication of patient grievances, help assure clinical competence through monitoring and maintenance of certification, protect patients from imposters misrepresentating themselves as PAs, and monitor the number of PAs working within the province.

3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.
Physician supervision is insufficient in certain practice settings. In remote or rural areas for example, PAs may be working far from a supervising physician for prolonged periods, in which case it would be in the public interest to have an additional quality assurance instrument such as regulation to maximize the mitigation of risk to the public. Regulation would also help ensure that PAs only work within their supervising physician's scope of practice and only to within the scope authorized by that physician. It would thus further reduce risk to the public by ensuring that an appropriate supervisory relationship is maintained.
4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.
Given the Controlled Acts listed under RHPA Section 27(2) which are performed daily by PAs through delegation, RHPA regulation is the safest and most appropriate way for PAs to be regulated. PAs typically develop broader knowledge as they continue to work with supervising physicians, and are thus delegated further acts under a negotiated autonomy as warranted by demonstrated competence. The NCP and Scope of Practice were developed with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada using the CanMEDS model.
5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.
CAPA demonstrates in their application that PA regulation by Colleges of Physicians and Surgeons has been successful in both Manitoba and New Brunswick. It has also been successful on a larger scale across the US. Regulation would permit provincial health care teams to easily research the profession and the credentials of individual PAs. Canadian Forces PAs welcome the opportunity to be regulated in their province of residence. Regulation by the College of Physicians and Surgeons of Ontario would enhance their ability to maintain clinical skills in civilian facilities, and thus their ability to competently fulfil their military health functions and to provide a provincially-acceptable standard of care whenever the Canadian Forces are mobilized to supplement provincial health resources in civil emergencies.
6. From your perspective, does the applicant convincingly demonstrate the extent of the impact by which the regulation of Physician Assistants will have on Ontario's wider health system? You may wish to comment on such issues as inter-professional collaboration, labour mobility, access to care, health human resource productivity and health outcomes.
Based on Canadian Forces experience, the employment of PAs in emergency and urgent care settings reduces wait times for care and the number of patients leaving without being seen. PAs working in non-acute care settings also shorten next available visit times and increase team productivity while maintaining high quality care. With adequate physician oversight, these advantages are safely attained at lower cost than would be achieved through the employment of an equivalent number of more extensively qualified clinicians. As physician extenders, they have permitted us to safely provide continuous primary care physician services to 100% of our population. PAs are trained to work within a team setting. They function very well within our civil-military collaborative practice facilities, which include physicians, nurse practitioners, nurses, medical technicians, pharmacists, physiotherapists, public health inspectors, and other health professionals. Consistent regulation across provinces would facilitate the maintenance of clinical skills by highly-mobile Canadian Forces PAs.
7. Do you have any other general comments?
The Canadian Forces perspective regarding PAs is not based on speculation, but rather on decades of direct experience ranging from low-risk directly-supervised

non-acute collaborative care settings to remotely-supervised independent duty in trauma-intensive mass casualty scenarios all over the world. Since World War 2, we have safely and effectively employed them or their equivalent on independent duty and within collaborative inter-professional clinical teams. As physician extenders, they have permitted us to safely provide continuous primary care physician services to 100% of our citizens in the Canadian Forces jurisdiction, including those in extremely remote and isolated locations, at less cost than would otherwise be achievable. Due diligence in adequately mitigating patient risks related to this benefit have, however, required a combination of centralized regulation at the level of the Office of the Surgeon General and the Canadian Forces Health Services Group Headquarters (the Canadian Forces professional regulatory college and ministry of health), additional regulatory oversight by the senior regional and senior local military medical authorities across Canada and abroad, and physician supervision at the individual PA level. Our perspective is that protection of the public would warrant PA regulation under the RHPA and, given their training and practice model, this would be most safely, efficiently, and effectively accomplished through the College of Physicians and Surgeons. authorities in Canada.

Respondent: Canadian Medical Association
1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?
The applicants have met all three conditions specified in the HPRAC Application Guide. (1) They are involved in duties, procedures, interventions, and/or activities which pose the potential for physical/mental harm to patients by virtue of the fact they are reviewing histories, conducting physical examinations, ordering tests, and making diagnoses. (2) They are making decisions/judgements which can have a significant impact on patients' physical/mental health. (3) The risk of harm exists within their professional duties and activities. As providers caring for patients, their regulation is a critical step in ensuring the success of the profession as well as safety of the public.
2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?
The creation of the PA profession with the express intent of improving care for patients through the patient-centred physician-physician assistant model of care demonstrates the extent to which the profession operates in the public interest. Regulation of PAs is one key way of ensuring that risk from harm is mitigated and that Ontario's patients are protected. PAs scope of practice is consistent with and/or exceeds that of other regulated health professions in Ontario. Regulation is essential to maintaining trust with the public, employers and other members of the collaborative team.
3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.
Existing mechanisms including physician supervision and certification of the profession are crucial elements in addressing the risk of harm arising from the PA profession, however, the addition of regulation is a compatible and necessary adjunct to ensure a professional standard of practice and to provide a mechanism for assessment, monitoring and discipline, should the need arise.

In the case of supervision, some tasks are performed jointly by a physician and PA, while there are other kinds of supervision which see the two professions working separately, and the PA being indirectly supervised. In the third type of supervision outlined (p11) it is seen that the PA may be seeing a patient while the supervising physician is out of the room or even in a different unit. Additionally, with the fourth type of supervision outlined (p11), PAs are supervised through management and periodic review meaning they are carrying out delegated activities based on medical directives developed with the supervising physician. The addition of regulation should not alter the physician - PA relationship and the requirement for supervision. These varied scenarios dictate that PA regulation is a preferred addition to supervision and certification.
4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.
PAs are engaged in a scope of practice similar to other regulated health professionals. I believe their submission convincingly demonstrates the need for regulation based on their interaction with patients which involves diagnosis, treatment and procedural interventions. PA training is closely modelled after that of the physician, involving a significant amount of interactive and problem based learning. The close relationship of civilian training program with medical schools in Toronto, Hamilton and Winnipeg speaks to their foundation based on the medical model. These schools are accredited through CMA's Conjoint Accreditation process while their national examination, certification and ongoing maintenance of competence process is also built upon these processes within medicine. Just as regulation is necessary for the profession of medicine and based on the close modelling of the PA profession with medicine, the addition of PA regulation is necessary for professional oversight, maintenance of competence and discipline. These roles cannot be fulfilled by the supervising physician or employer.
5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.
While I don't believe that the establishment of a separate college would not be feasible at this time the College of Physicians and Surgeons of Ontario seems a likely body under which to house PA regulation. This would mimic what has been done in Manitoba and New Brunswick. There remain concerns with respect to the cost implications for CPSO and their existing physician members. A sustainable funding model will need to be created that does not negatively impact physicians. These discussions are best dealt with by CPSO and the provincial government.
6. From your perspective, does the applicant convincingly demonstrate the extent of the impact by which the regulation of Physician Assistants will have on Ontario's wider health system? You may wish to comment on such issues as inter-professional collaboration, labour mobility, access to care, health human resource productivity and health outcomes.
PAs have the potential to extend the ability of physicians to enhance access to care for patients while improving both patient and provider satisfaction. The physician-PA model defines inter-professional collaboration in a manner consistent with CMA's Policy on "Achieving Patient Centred Collaborative Care" (see www.cma.ca). Given ongoing HHR challenges and the growing burden of chronic disease, collaborative models of practice will be essential to improving the quality of patient care going forward. Furthermore, the PA model is collaborative with other members of the health care team including NPs, advanced practice nurses, pharmacists and other health professionals. Models exist in Ontario that demonstrate a complementary role for both PAs and NPs in a variety of settings including primary care and Emergency Medicine. Of course, the Canadian military have been demonstrating this type of collaboration for decades.

7. Do you have any other general comments?
The CMA supports the integration of PAs in practice across Canada. Evidence from both Ontario pilot projects and the Manitoba experience have demonstrated the value of PAs in improving access to care, chronic disease management, patient and provider satisfaction and a reduction in wait times amongst other benefits. The strength of the PA role is founded on the close working relationship with physicians in extending physician capacity. A sound PA education curriculum, comprehensive core competencies, an accreditation and certification process are necessary but not sufficient. The future of the PA profession will be contingent upon a sound regulatory framework to ensure patient, public and provider trust and a sustainable funding model for the future. I would refer you to the submission of the Ontario Medical Association for a detailed analysis of the Ontario experience. Thank you for the opportunity to comment.

Respondent: College of Chiropodists of Ontario and The Ontario Podiatric Medical Association and the Ontario Society of Chiropodists
1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?
[This submission has been prepared jointly among the College of Chiropodists of Ontario, the Ontario Society of Chiropodists and the Ontario Podiatric Medical Association. As HPRAC knows, the Chiropody/Podiatry review is in the HPRAC pipeline. The three organizations have agreed to work collaboratively on all matters pertaining to the Chiropody/Podiatry review to the extent that their respective mandates permit. Given that such a working relationship has already been institutionalized, the three organizations determined that there was a consensus with respect to the physician assistant review and, therefore, a joint submission would be both appropriate and cost-effective.] As is the case with respect to many of the questions, it is difficult to formulate a response in this case because the CAPA application does not set out HOW it sees physician assistants being regulated by the CPSO. The relevant section of the Application ('Recommended Regulatory Mechanism'--page 21) is light on details. Does CAPA propose that Physician Assistants form a class of members within the CPSO (as, incidentally, is the case with podiatrists within the College of Chiropodists and on which, therefore, we could have provided considerable insight), that the CPSO administer a register of certified physician assistants, or something in between or completely different? We note, in this regard, that CAPA claims only to have had 'preliminary discussions' with the CPSO and the CPSO 'is exploring' the regulation of PAs by the CPSO. Accordingly, it is impossible to assess whether the risk of harm described is appropriately addressed by the regulatory model proposed. Furthermore, the CAPA application has not explained why the current model (whereby everything that physician assistants do is done pursuant to supervision by or delegation and assignment from a physician) is inherently inadequate, or has proven to be inadequate or ineffective in addressing the risk of harm. The CAPA application indicates that physician assistants already practise "within a formalized physician/PA relationship', but does not describe how those formalized relationships inadequately protect the public interest and why regulation under the RHPA is necessary to do so.

In sum, therefore, we conclude that CAPA has made a compelling argument for some type of professional regulation, but not necessarily regulation as a profession under the RHPA. Since (paraphrasing the CAPA Application at page 27) Physician Assistants are able to practise only with a supervising physician, pursuant to which the supervising physician delegates patient care responsibilities to the PA, we defer to the physician community to determine the best mode and mechanisms of regulation to protect the public interest.

2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?

There is no question that the public interest would be served by having physician assistants identified as a profession that is directly regulated under the RHPA. We believe, however, that the more pertinent question in this case is whether regulation under the RHPA is the most cost-effective method of serving and protecting the risks to the public interest identified in the CAPA application.

Statutory protection of titles, articulating and enforcing consistent entry to practice requirements, making available a public complaints and disciplinary process, requiring professional liability insurance, enhancing labour mobility and so on, is each clearly in the public interest. Nevertheless, the CAPA application falls somewhat short in making a compelling case that the creation of a profession-specific Act under the RHPA is the most cost-effective way to achieve the objectives listed in that application.

3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.

In our view, this question is really the heart of the matter. As already indicated, we do not believe that the CAPA application has explained how the existing mechanisms of supervision, delegation and assignment have fallen short in protecting the public interest, if in fact they have; and if they have, why those mechanisms are inherently unable to protect the public interest.

For example, could the public interest objectives identified in the Application be served equally well by the CPSO establishing and maintaining a registry of Physician Assistants,as is the case in other jurisdictions? By regulation, or otherwise, the CPSO could specify that physicians may enter into a physician assistant relationship only with individuals listed on the registry. Listing on the registry would require each individual to have the minimum certifications and competencies required by the CPSO, minimum levels of professional liability insurance and whatever other requirements the CPSO could lawfully impose in the public interest.

4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.

We have several misgivings in this regard:

CAPA indicates that

'A first and overarching observation about the practice of PAs in Ontario is that the practice is evolving and changing rapidly.'

At numerous points in the Application, CAPA reinforces and provides evidence of the newness of the profession in Ontario and the 'state of flux' in which it finds itself.

This inevitably prompts the question as to whether now is the right time to determine the regulatory model and mechanisms for physician assistants, or whether time should be taken to allow the profession to stabilize, grow and mature.

Furthermore, given that CAPA claims only to have had 'preliminary discussions' with the CPSO and indicates that the CPSO 'is exploring the regulation of Pas,' one wonders if the application is not premature and should be held in abeyance until these discussions arrive at a more developed state to present to HPRAC and the government for consideration

5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.

Once again, it is difficult to answer this question because of the absence of details as to precisely how physician assistants are proposed to be regulated as part of the College of Physicians and Surgeons of Ontario. Nevertheless, because the CPSO is a well-established regulatory body, there is no question that regulation of PAs by the CPSO is entirely practical regardless the model and mechanism of regulation.

Furthermore, we have no doubt that the profession understands the implications of regulation and agrees that the relatively small number of physician assistants who currently practise in the Province make a stand-alone College for PAs likely unsustainable. The CPSO appears to be the obvious and the best choice of regulatory body.

We also note the recommendation in the application that the Ministry of Health and Long-Term Care provide transitional funding to the CPSO 'so the cost of PA regulation does not become a burden to physician members'. We wonder why the PA profession is itself unwilling or unable to carry this burden, as has been expected of other professions seeking regulation under the RHPA--with the notable exception of midwifery.

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

Neither chiropodists nor podiatrists have had the opportunity to work with physician assistants to any significant degree. Nevertheless, there is no doubt that the advent of physician assistants has made a positive contribution to Ontario's health care delivery system and that contribution will continue to grow as the profession grows and evolves. The College of Chiropodists, the OSC and the OPMA unequivocally support and welcome the introduction of physician assistants in Ontario. Those positive impacts, such as freeing up physicians' time, enhancing productivity through human resources substitution, reducing wait lists and facilitating labour mobility, have been well documented in the Application.

The question that the Application could have better addressed is how RHPA regulation can be expected to reinforce, accelerate or add to those positive contributions.

7. Do you have any other general comments?

As is probably clear from the foregoing answers we have struggled with this Application for regulation under the RHPA. On balance we support physician assistants being regulated as a profession under the RHPA, but for several reasons not specified in the CAPA application:

• The scope of practice and role of physician assistants needs to be articulated a directly enforceable to provide clarity and confidence to other professions and

thereby enhance interprofessional collaboration beyond the physician community;
• So that Physician Assistants are not exclusively accountable to and controlled by their employers; and
• So the public and other practitioners may have access to a complaints and disciplinary mechanism that applies directly to Physician Assistants.

We also wish to acknowledge the very important role physician assistants currently play and the greater role they are poised to play in health care delivery in Ontario. If regulation under the RHPA supports that role, that is justification enough in our view ---- and we wish them the very best.

Respondent: College of Dietitians of Ontario
1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?
1. Yes, in the College of Dietitians' view, regulation under the RHPA is recommended to mitigate the 'risk of harm' to the health and safety of the public. The College notes that PAs work under delegation and supervision of Physicians which for some roles may be sufficient public protection. However, as described, the role of PAs includes a lot of self initiated activities including controlled acts and ordering/prescribing treatments that would begin before a Physician reviews the order/prescription. This level of autonomy presents sufficient risk of harm. The public would benefit from increased protection from harm as would be provided through regulation under the RHPA. Specifically, this College believes that the public would benefit from having PAs held accountable and responsible for their professional decisions and how they rely on the changing body of medical knowledge and evidence based practice.
2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?
2. Yes. The CAPA has made a good case supporting the need for regulation in order to protect the public. While there is little available information about patients being harmed, the potential for harm is clearly evident from the broad scope of practice and the expectation of the independent or autonomous professional decision making and the PA's reliance on a complex and changing body of knowledge. Given the level of potential harm, the public's interest would be served through the regulatory instruments and functions provided through the RHPA. In the view of the college there are no apparent consequences of regulating PAs under the RHPA that would work against the public interest.
3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.
3. Effectively, the education and scope of practice of PAs has been controlled through demonstration projects, and the quality of practice is supported through supervisory relationships. The profession at this time is very small. It is the view of the College that the current structures would be insufficient to support a growing and maturing profession in a way that would assure the public of high standards. Regulation under the RHPA would enable an organization, specifically a college, to ensure over time that the education, entry to practice, professional standards, and practice supports were in place to assure high quality patient care as the profession expands. It is insufficient to rely on individual physicians or a voluntary advisory group to fulfill these functions. It is also important that the public have a way to have their concerns about a Physician Assistant dealt with other than by reporting it to a physician colleague/supervisor or an employing facility.

The College does not see any viable options to regulation under the RHPA.
4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.
4. Yes. The applicant has reasonably demonstrated that regulation under the RHPA is appropriate based on a complex and changing body of medical knowledge,a degree of autonomous decision making in practice, and a reasonably defined scope of practice. PAs have demonstrated value as a members of health care teams willing to work collaboratively within a professional culture that embodies accountability and client centred care. It is difficult for the College to determine the sufficiency of of the current education (2 years plus previous health professional background/preparation). This College does appreciates that the role, and hence the entry to practice competencies, may change over time. It would be beneficially to have a regulatory body in place to provide continuous monitoring of work place and client needs and to require educational programs to meet standards to reflect these needs.
5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.
The applicant has not presented the business plan, prediction or forecasting of costs and they seem to be relying on the Ministry and/or the College of Physicians and Surgeons to carry the cost of regulation. This College would accept the notion of financial support, expecting that the profession would grow over time to eliminate the need for this type of financial support. There is a lack of evidence/data to supporting members willingness to pay membership fees, however, CAPA showed an appreciation that the cost per PA would be significant.
6. From your perspective, does the applicant convincingly demonstrate the extent of the impact by which the regulation of Physician Assistants will have on Ontario's wider health system? You may wish to comment on such issues as inter-professional collaboration, labour mobility, access to care, health human resource productivity and health outcomes.
Physician Assistants are described as health care providers with knowledge, skills and attitude to undertake delegated medical procedures. They are not an independent practitioner, but extenders of physician's roles. The College is of the view that integrating Physician Assistants into Canadian health care will increase the level of service for clients by helping to facilitate timely access to care and a team approach. The College recognizes the resource pressures on the health care system, especially in face of a growing, aging population. From a health care system/economic perspective, the scope of practice of Physician Assistants is designed to help reduce wait times and help ensure that the right care is provided by the right provider at the right time. The PA presence in the health care system may enable MDs to apply expertise where best used. The structures and functions provided through regulation may well enable growth of the PA profession which would provide economic benefits worth supporting.
7. Do you have any other general comments?
This College would support the idea of regulating PAs through the College of Physicians and Surgeons. The roles of PAs and Physicians are closely aligned, drawing on the same body of knowledge and evidence for practice. MDs and PAs also share the care for the clients Regulation by the CPSO would enable the development and implementation of compatible PA and Physician standards, QA and ICRC processes and reduce the possibility of conflict between the two related professions. It also presents the most cost-effective option.

Respondent: College of Respiratory Therapists of Ontario
1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?
Not necessarily. The primary risks articulated in the CAPA submission under the primary criterion centre on the relationship with the supervising physician. The MD holds the primary responsibility for the activities to be carried out by the delegatee, in this case the PA, and this responsibility has redress through the CPSO in instances of breach. In current practice, there are several professions who act on direction from a physician, some of which are self-regulated, have an independent scope of practice and are accountable to their regulatory body. A close approximate may be the MD relationship with a Nurse Practitioner, which may be ideally cemented via a collaborative practice agreement, or even with an advanced practice physiotherapist in the orthopaedic surgery setting. Others are not regulated and have a similar delegation process for authorization, along with a mirroring of physician scope to define their role. An orthopaedic technician working with an orthopaedic surgeon would be a good example of this. in this second scenario, the MD holds primary responsibility for the performance of the ortho tech; the employer would also hold some responsibility for performance of the employee. The risk described in the submission appears to occur if either the delegator or delegatoee fails to properly execute their responsibility (eg. the PA exceeds their defined scope of the MD fails to adequately supervise the PA). In this case, concerns could be directed to either the CPSO or to the employer. As such, the submission does not make a convincing argument for how this would be better addressed through self-regulation (ala the NP model) rather than focusing on improved supervision of the PA by the MD and/or employer (ala the ortho tech model). That being said, the totality of the CAPA submission suggests that the PA role will expand to areas where MD supervision will be diminished, requiring more independent action on the part of the PA. If so, then it would be a scenario where the potential for risk of harm will be higher than in the institutional setting (with closer working proximity to the MD) and that risk would be well addressed through self-regulation.
2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?
No additional comments.
3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.
No additional comments.
4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.
In some instances, yes. The submission notes that PAs are trained as generalists; they then tend to specialize their practice in alignment with the physician and location. This is not dissimilar to other professions. I does follow that professional development will be a core component of the PA role post-training. There would likely be some benefit in using a Quality Assurance program through a regulatory body to support this development and align with the public interest.

If self-regulated, any scope of practice boundary violations could be redressed via an Inquiries, Complaints and Reports process if self-regulated (although, this is not the only option for addressing these scenarios). This is suggested in the submission. The focus of the submission does appear to be hospital-centric. If practice were to extend beyond an institutional setting where supervision is diminished (the fourth type of supervision, as described in the submission), regulation under the RHPA would become more strongly indicated. In cases where the number and frequency of controlled acts being performed is high, regulation under the RHPA would be more strongly indicated. There is the suggestion that this would be the case with PAs, as per the submission.
5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.
The model proposed, where the PAs are regulated under the CPSO, seems essential. With the high costs of conducting investigations and/or disciplinary proceedings, both of which must be considered a possibility in light of their proposed broad role and proximity to the MD, the ability to leverage the existing infrastructure of the CPSO would be highly beneficial, considering the relatively low number of projected registrants (400 registrants x $800 annually = 320,000 annual operating budget). There was one comment abut the practice of employers reimbursing practitioners for their registration costs. This has not been our experience.
6. From your perspective, does the applicant convincingly demonstrate the extent of the impact by which the regulation of Physician Assistants will have on Ontario's wider health system? You may wish to comment on such issues as inter-professional collaboration, labour mobility, access to care, health human resource productivity and health outcomes.
Role clarity and the application of the principles of interprofesisonal collaboration will be helpful in addressing scenarios of overlapping scopes of practice and shared accountability. Would suggest careful consideration of the controlled act of prescribing, recognizing the distinction between the the act of "prescribing" vs. "ordering". Would suggest clarification of the issue of liability in scenarios of shared accountability (such as with delegation or collaboratively-defined scope of practice).
7. Do you have any other general comments?
Thank you for the opportunity to comment. No additional comments.

Respondent: Hamilton Health Sciences
1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?
1. The proposed scope of practice of the PA will mirror that of the physician partner supervising them. Every act performed is one that is delegated by a physician who is competent to perform themselves. This will pose a risk to the public as it is not the actual physician performing it. 2. Inappropriate behaviors, practice incompetencies, impairment while practicing, practicing outside of their scope, possible sexual relations with patients, criminal activity and lack of moral character are all risks associated with this role and responsibility. Mechanisms need to be in place to reduce this risk and mitigate it. Regulation will support mitigation and in the reduction of risk. 3. Within the various models of care delivery proposed for PAs there may be "posers" who lack the required training and skill to perform their jobs. This will create risk to the patient. Regulation will create a minimum standard that all PAs will require to proceed in any environment 4. A mechanism of redress and reprimand and possible mandated further training or supervision will be required by the regulating body if the member does not meet the minimum standard. This will reduce risk to the public.
2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?
1. Please refer to the answers in question 1. 2. The public will become more informed of PA practice and will have a method of recourse if there are complaints or concerns, through the regulatory body. Currently there is no mechanism for this. 3. There would be confidence that a regulatory body will create and supervise the PA scope of practice, ensure standardized accredited educational programs are in place. The regulatory body will also create a means to upkeep competence and a quality assurance process to assist this in the PA profession.
3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.
1. Regulation of PAs will ensure all PAs are licensed to a minimum standard within their scope of practice. 2. Ensuring a PA is regulated will eliminate questions of where to start with training and supervision and if the PA does indeed have the necessary skills to start in the various roles. 3. Currently in the hospital sector the application of Medical Directives is a bit "foggy" when involving the PAs as they are unregulated. This creates a necessity of coimplementing the Medical Directives,which causes confusion to other health care professionals who are regulated. With regulation the PA supervising physician will delegate controlled acts based on the PAs competencies. The PAs will be authorized to perform controlled acts under the RHPA. This will make the Medical Directive process more "clear" for the team and other Health Care Professionals.

4. With the above being so, more clarity is required to educate other members of the Health Care team about the PA role, scope of practice and what the notion of supervision means through a physician.

5. PAs currently work in some care models with minimal supervision. Especially in these cases, it is important that all team members and patients understand the PA role and responsibility. With regulation the PA will have a built in accountability mechanism as they are responsible for their own practice. Currently with the unregulated model the supervising physician is responsible for their practice. Regulation with clearly stated methods and standards will help guarantee the public that an accountability mechanism has been established.

4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.

1. Graduating from an accredited school the PA will be considered a generalist when it comes to application of their practice.

2. Specialized roles and responsibilities after graduation are based on the supervising physician they will work with. This can vary in many ways.

3. It is hard to determine competency from a regulation perspective with the various roles and responsibilities they may be involved in.

4. It is not clear who will determine what the necessary certification process will be for each of these potentially high risk tasks, roles and responsibilities. Will it be the supervising physician or the regulatory body? There could potentially be several approaches and this goes against the grain of standardization. Regulation requires a minimum standard and this may be difficult to obtain with the model of training the various PAs will receive on the job after graduation.

5. Will there be different streams the PAs can enter after graduation? How will this be managed and monitored to ensure a minimum standard of training and certification is maintained? Will the PAs be required to maintain a roster of the skills they perform and be able to demonstrate that they can perform them? How will their competence be demonstrated and maintained on an annual basis? These are just a few questions other regulated providers are asking as it is a requirement from their own colleges.

6. Should the CPD credits be streamed into a quality assurance mechanism to ensure it meets the specific needs of each PAs individual practice? This may be a challenge with the various areas they could work in.

7. The relationships of the PA and MDs should be clarified. Section 3#3 - the role is simply so new to the field that the system has not grappled with their roles, scopes and fit. Section3#5 - that some PAs are functioning with "minimal supervision" flags that some physicians may not understand the roles well and their accountabilities. There should not be variability in understanding and enacting the supervision of the roles, whether they are regulated or not. Understanding that some PAs may have greater competency and skill, the accountabilities for supervision and performance review and development should be clear on the part of the MD and the PA.

8. An accredited PA school program will be essential. We would be interested in knowing if the Ontario PA Schools are currently accredited and if so, what mechanism was followed to ensure this?

9. Is Ontario hiring graduate from other provinces? Is a PA from the military program being handled differently in their training for other applications in the health care field? This would be helpful information. 10. Assessing ongoing competency is probably quite variable across Ontario. With the roles being so new, how are the hospitals equipped to support these issues with so little experience with the role? 11. The 2 year general program is short and yet the proposal is that the PAs will take on work with people that can be very complex. Is this enough? Or, is the scope narrow enough to minimize the concerns for risks? Given that we have internationally educated MDs in some of these roles, therein lies some other dilemmas when they think they can function in an expanded role and yet they are not meant to. This could cause a variability in practice.
5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.
1. Currently the number of PAs in Ontario is below 200. The financial requirements to start up a regulatory college of this nature can have quite an impact. This will reflect on the membership dues, which will be significant to them. As an example the CRTO currently has just under 3000 members in Ontario and the membership dues are $500 a year. One can imagine how much it will cost to maintain and support a college with less than 200 members. 2. Being the PAs work so closely with their supervisor physicians and that the physicians need to endorse this relationship, it would make sense to have the PAs regulated under the CPSO. 3. It would be important to hear the CPSO's opinion on this approach. CPSO input has been silent in the provided documentation on this matter. 4. If PAs were regulated it would make the process of determining competence ideal for hiring institutions. A standard license would be required from every PA and the institution would feel confident at that time that the minimum competencies have been met. 5. Hospitals are not commonly in the business of reimbursing college membership fees. The PA would be required to pay this personally, which may hinder the application process. 6. Some questions arise about how PAs would be salaried (By the organizations that hire them is an assumption at this stage)? With this, would supervising physicians be asking for a stipend and also bill for the work the PAs are completing, in addition to their own direct billing? If this were the case, would it make more sense for the supervising physicians to salary the PAs. It would be helpful to get clarification on this process.
6. From your perspective, does the applicant convincingly demonstrate the extent of the impact by which the regulation of Physician Assistants will have on Ontario's wider health system? You may wish to comment on such issues as inter-professional collaboration, labour mobility, access to care, health human resource productivity and health outcomes.
1. PAs working closely with physicians, would be involved in collaborating with many other health care professionals and providers to meet the patients needs.

2. PAs would become a member of the interdisciplinary team to help increase productivity, as long as all team members had a clear understanding of their role, scope of practice and how they fit into the team. This being a newer role in the hospital systems, this will likely take some time.

3. PAs may help fill the gap with the physician shortage in the province of Ontario. Throughput in the ambulatory and ED areas have potential to improve if the PAs role was clearly laid out and integrated in these areas.

4. Currently PAs are regulated in the provinces of Manitoba and New Brunswick through their respective colleges of physicians and surgeons. They are required to pass a PACCC PA Certification Exam. If Ontario adopted this, there would be a national standard that all PAs would be required to meet. Labour mobility would only be enhanced within Canada if PAs became regulated in Ontario, meeting the same standards.

5. An increased respect among other health disciplines would also be encouraged with PA regulation. This being tied to a better understanding of the role, responsibility and scope of practice.

7. Do you have any other general comments?

1. The PA role is a new role in Ontario, and it is a significant risk and/or opportunity to proceed with role regulation, established elsewhere, that is patient centered and as cost effective as possible. The role is not new to other provincial bodies and we should actively learn from their experience and move forward in a timely fashion with regulation of Physician assistants.

2. Regulation under the CPSO make sense as the PA role is linked to the MD roles and responsibilities and any quality assurance follow up will need to incorporate the activity of the supervising physician.

3. The generalist 2 year program with an additional "internship" timeframe with a supervising physician is an idea to discuss before a PA becomes certified.

4. Within Hamilton Health Sciences 2 PAs have been hired within one of the ICUs (Cardiac ICU). Mindful consideration has been put in place though a Steering Committee to ensure adequate training with Physicians and other key health care practitioners is taking place. Supervision for the PAs is provided by the attending intensivist. On going evaluation and feedback takes place at the bedside and in formal face to face discussions. Learning logs are kept by each of the PAs to keep track of what they have learned and performed. Medical Directives tailored to the PAs functional requirements are in process of approval and have been coimplemented with Professional and Practice expertise. The ICU team continues to work closely with the PAs and the understanding of their role and responsibility within the Cardiac ICU is improving with time.

Respondent: Nurse Practitioners' Association of Ontario

1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?

The Nurse Practitioners Association of Ontario (NPAO) is responding to the CAPA (January 2012) submission and other referenced materials. It is the intent of

NPAO to speak only to Physician Assistants (PAs) who are working with and within the civilian population of Ontario. We are not generalizing our comments to those medics and/or Physician Assistants who work in the military within DND. It is the belief of NPAO that there are significant differences between PAs working in the military versus those working with the civilian population in Ontario. NPAO has great respect for the PAs in the military who have a lengthy history of providing service to their military comrades and to individuals in communities while stationed overseas. It is our understanding that the training, education, and supervision of PAs in the military is markedly different than that of their civilian counterparts and therefore the experience and outcomes are not generalizable.

It is the position of NPAO that CAPA has not met the "risk of harm" threshold. It is the position of NPAO that there is currently insufficient data to determine the risk of harm that the recent introduction of Physician Assistants (PAs) has posed to public safety in Ontario. As stated by CAPA, the introduction of PAs in Ontario is in infancy and there is a dearth of published literature regarding PA practice in Ontario and Canada (p.4).

The application for regulation as submitted by CAPA (January 2012) states that the PA profession "burgeoned with the Demonstration Projects, which commenced in 2006" (p.4). In actual fact, in Ontario, the first civilian program to train Physician Assistants admitted 21 students initially in the fall of 2008 (McMaster University website) - less than 4 years ago. According to the CAPA submission, it is unclear exactly how many PAs have been educated in Ontario (p.14). CAPA does not have the exact numbers. It would appear that, to date, 45 students have graduated from McMaster University and 17 more are expected to graduate from the Consortium Program in June 2012.

According to HealthForceOntario (2012), the PA demonstration projects and grant projects are currently underway. The MOHLTC is awaiting the results of a comprehensive evaluation of the various demonstration projects which are measuring the performance of PAs as well as capturing risks and benefits to the public. NPAO would recommend that the MOHLTC await the outcome and evaluation of these demonstration projects in order to evaluate the efficacy and safety of PAs.

The CAPA submission states that "PAs and physicians are mutually responsible to each other and even dependent upon one another" (p.8). In actual fact, "PAs are unregulated health care providers who perform clinical work including delegated controlled acts as assigned by a supervising physician who is ultimately responsible for patient care." (OHA, July 2011). While it is clear that PAs may expose the supervising physician to increased liability due to negligence, it is unclear at this time what additional risk has occurred to the supervising physicians. As stated in the application, CAPA "...is unable to provide a 10 year history, or any history for that matter, regarding the rate and nature of complaints in Ontario (2012, p.8)". The Jurisprudence Review completed by the Secretariat of HPRAC focuses primarily on complaints and malpractice suits that have occurred in the USA. It would be essential to consider actual, verifiable data over a significant period of time regarding the outcome of care to patients and the vicarious liability assumed by both employers and supervising physicians before drawing conclusions regarding the risk of harm to the public.

In Ontario, Nurse Practitioners (NPs) practiced for more than 30 years before becoming regulated health professionals. Over that 30 year period, NPs were able to demonstrate a pattern of safety, not just anecdotally but in randomized controlled trials (Spitzer et al., 1974) and meta-analyses (Horrocks, Anderson, Salisbury, 2002; Newhouse et al., 2011).

As well, for the sake of comparison, it is significant to note that HPRAC is concurrently considering a proposal for Dental Assistants in Ontario to be regulated under the RHPA. In comparison to the short history of PAs, the Ontario Dental Assistants' Association became an incorporated, not-for-profit association in 1934 (78 years ago). Dental Assistants have been educated and certified since 1960. The 8,500 members of ODAA are currently applying to be regulated under the

RHPA.

In conclusion, the CAPA application has not met the primary criterion. The applicant has not demonstrated with relevant, verifiable evidence the risks associated with the practice of the PA profession, as distinct from the practice of the supervising physicians with whom the PA works.

2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?

Please refer to the response to question 1. As stated previously, it is the position of NPAO that the CAPA application has not met the primary criteria, that is, the application has not met the "risk of harm" threshold.

It is the position of NPAO that the application by CAPA (January, 2012) has not convincingly demonstrated that it is in the public interest that Physician Assistants be regulated under the RHPA at this point in time. It is the position of NPAO that a full and comprehensive evaluation of the demonstration projects and Grant Projects should be completed to assess the efficacy and safety of this new role in Ontario. One would then expect that verifiable data would be available for scrutiny to determine the efficiency, productivity, quality, and safety of this fledgling group. No doubt the Ministry of Health and Long-term Care is conducting an ongoing jurisprudence review of the PA role as part of the demonstration projects. Naturally, if concerns arise during the demonstration phase of this project that threaten public safety or jeopardize care to patients, the Ministry should make every effort to terminate the project early.

3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.

It is the view of NPAO that there is insufficient relevant and verifiable evidence available to demonstrate that the current mechanisms in place such as the certification and supervision of PAs are insufficient to address the risk of harm to the public at this time.

Currently there is no dispute that PAs have been introduced in Ontario to do exactly as their title implies: assist physicians. In the pilot projects, this is being done in the context of a formalized physician/PA relationship within which the supervising physician determines the tasks to be assigned to the PA working under them. As CAPA (2012) has articulated: "Every act performed [by a PA] is by agreement with the physician. Every act performed by the physician is one delegated by the physician and one which the physician is competent to perform him or herself." (p.6) Therefore, at the core of patient safety is the sufficiency of the physician/PA relationship with clearly understood mutual responsibilities, appropriately delegated activities, and proper supervision by the physician(s).

During the demonstration phase of the PA project, there are several mechanisms in place to mitigate the potential risk of harm to the public.

Malpractice Coverage is available for all physicians who have chosen to supervise and/or work with a PA. The CPSO should ensure that physicians participating in the pilot projects have access to adequate comprehensive general liability coverage for the protection of all parties involved, most notably to protect the public. It is reassuring for the public to know that the supervisory physicians can access general liability coverage through the Canadian Medical Protective Association (CMPA). CMPA has indicated that it will consider the clinical work a physician performs while supervising a PA the same as other clinical activity and will consider providing assistance in the same manner if a claim arises against the supervising physician (OHA, July, 2011).

For the protection of the public, all employers should stipulate that the PAs have full general liability coverage.

It is the understanding of NPAO that the Healthcare Insurance Reciprocal of Canada (HIROC), who is the healthcare liability insurance provider for many of Ontario's hospitals, CHCs and FHTs, have confirmed that their general liability coverage extends to employed PAs. In an excerpt form an OHA policy paper, HIROC states that:"All employees of HIROC subscribers are covered by HIROC. Therefore any PA, or individual working in a PA-like clinical role, who is an employee of a HIROC subscriber, will be covered by virtue of their employee status." (letter from HIROC dated February 7, 2007, excepted from the OHA document "Understanding Liability related to the employment of Physician Assistants, July 2011).

Physician exposure to risk may be minimized by ensuring that MDs provide appropriate authorization and supervision of PA practice at all times. Guidelines are available to assist physicians with the supervision of the PA, including the expected process for delegating controlled acts in accordance with the CPSO's policy on delegation. The CPSO policy on delegation states that the delegation of a controlled act may take place in one of two ways: by direct order regarding the care of an individual patient or by medical directives, usually in the context of a pre-established physician/patient relationship. As the policy states "There remains an assumption that delegation is inappropriate in the absence of a physician-patient relationship, but in limited circumstances and only when the timely delivery of medically necessary treatment is required, delegation may occur absent a physician-patient relationship." (CPSO, 2010). Supervisory physician are encouraged to follow these guidelines closely and diligently to minimize any potential liability exposure(OHA, July, 2011). Furthermore, CMPA has set out strongly worded directives on liability exposure for MDs working in collaborative care as well as the risk of liability physicians assume by supervising a PA (Sproule, 2010). Patients can be reassured to know that ultimately, the accountability and responsibility for their care rests with a regulated health care provider, the supervising physician.

The CAPA submission states that there are a variety of types of supervision which range from the physician being present in the room while the PA is performing the task to the supervision being carried out by way of management and periodic review. CAPA proposes that the latter type of supervision may occur in the absence of a physician-patient relationship, whereby only a percentage of the PA's charts are seen and reviewed by the supervising physician (p11). The CAPA submission goes on to say that, "As the physician separation becomes more apparent, the patient is left more dependent upon the PA and therefore more reliant on the judgment and decision making process of the PA and hence the autonomy of the PA evolves."

It is the position of the NPAO that the best interests of the public are served when the supervising physician has a close, physically-proximal relationship to the PA they are supervising. Furthermore, the risk to the public is mitigated when physicians closely follow the CPSO directive on delegation. At this point in time, safety concerns should be addressed through adequate supervision. PAs should be disciplined as any other unregulated health care worker would, as an employee of their supervising physician and/or employer.

It is the understanding of NPAO that CAPA currently recognizes PAs who have successfully completed an PA educational program recognized by the Physician Certification Council of Canada (PACCC). PACCC is an independent council that administers and maintains the PA certification process. The CAPA application details the way in which CAPA helps to ensure continuing professional development.

4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.

HPRAC seeks to establish if there is an intersection between body of knowledge and scope of practice. Scope of practice refers to the rules, regulations, and boundaries within which a qualified health professional with appropriate training, knowledge and experience may practice in an area of health care (HPRAC Application Guide). The scope of practice statement should describe in a general way what health care services are provided by that group of professionals particularly as distinct from other groups of health care professionals.

It is difficult to discern if there is an established intersection between a body of knowledge and scope of practice with respect to PAs. By definition, PAs exist to assist physicians, as physician extenders. They exist as a health care provider only viz a viz their supervisory physician.

There is no dispute that, currently in Ontario, Physician Assistants do not have a defined or autonomous scope of practice. According to CAPA (2012), "their [PA's] scope of practice mirrors that of the supervising physician(s); therefore the nature of services provided are entirely dependent on the practice of the physician(s) with whom the PA is associated." (p.6). Furthermore, the services they provide are only defined by the delegation under which they practice. "Every act performed is by agreement. Every act performed is one delegated by the physician and one which the physician is competent to perform him or herself."

Currently it would seem that the scope of practice for a PA relative to the scope of medicine is everything and yet nothing. As articulated on pages 12 and 13 of the CAPA submission, PAs currently perform (or will perform in the future) all of the controlled acts authorized to medicine except that of prescribing a hearing aid for a hearing impaired person. In fact, the CAPA submission states that in some settings, PAs are performing the only controlled act that medical physicians are not authorized to perform in Ontario, i.e., fitting or dispensing a dental prosthesis.
Although it would seem that the PA scope currently encompasses the entire scope of the practice of medicine (and then some), at this time PAs currently do not have independent authority to perform any of the controlled acts in the absence of a direct order or a medical directive. There is a substantive difference between performing a controlled act under delegation and supervision and having the knowledge, skill and judgment to initiate a controlled act independently.

The CAPA submission emphasizes that the PA scope of practice differs from setting to setting and is dependent upon the specialty area and/or expertise of the supervising physician: "the nature of services is entirely dependent on the practice with whom the PA is associated". To say the PA scope of practice is not well articulated is missing the point. In truth, it seems that the PA scope of practice is nebulous and amorphous. NPAO looks forward to having the PA scope of practice better defined and well delineated.

We contrast this again to the application for regulation from the Ontario Dental Assistants Association (2011). It is no wonder that after 78 years of practice in this province, dental assistants are able to clearly articulate their scope of practice and the associated body of knowledge and skills that goes with that scope.

Many professions prepare as generalists and then, through further preparation such as graduate studies and certification, become specialists over time. But it is clear that some PAs go from a generalist preparation directly into a specialist role. Given this disconnect, it is impossible to decipher what the core competencies for this role are for entry to practice. What are the qualifications and body of knowledge that would prepare someone who can potentially do everything an orthopedic surgeon does and/or everything that and/or everything a general practitioners does after a two-year PA program?

5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory

regulation.

Economic Impact of Regulation:
There is some information available regarding the economic impact of Physicians Assistants but more information is needed in order to assess the economic implications of statutory regulation. CAPA (2012) states in its application that it is aware that there would need to be a substantial investment of time and resources to regulate the PA profession; however, these costs remain obscure (p.20).

The costs to the profession itself as well as to the healthcare system must be taken into consideration. Tuition and educational materials for the PA program are estimated at $12,500 per year per student (McMaster University website). These costs do not include living expenses during the PA program or the prerequisite undergraduate studies. Further costs to the individual PA would be incurred for college dues, continuing education, and liability coverage.
Costs to the health care system currently include the PA salary and associated expenses. The CAPA application indicates that salary of a PA ranges from $75,000 to $125,000 per annum plus benefits. HealthForceOntario has indicated that grants between $46,000 and $92,000 per annum per MD have been provided from the MOHLTC to eligible supervisory physicians and/or employers that hire Physician Assistants. Kulatunga-Moruzi (2011) surveyed 22 supervising physicians of the first class of graduates from the McMaster PA program. According to the author of this study, supervising physicians reported that the provision grant money for the PA salary was very influential in their decision to hire a physician assistant. Furthermore, most respondents reported that they were unlikely to have hired a PA if the grant program had not been available. Respondents also reported that they would be unlikely to hire another PA if no further government funding were available. The sustainability of the financial incentives for MDs to work with PAs in the context of the current fiscal climate would need to be considered by health economists and taxpayers alike.

Currently, the Ontario OHIP fee schedule only pays physicians for "personally" providing insured services to individual patients. The current fee schedule does not allow physicians to bill for the services delegated to and provided by a Physician Assistant. The Ontario Medical Association advocates that the fee schedule be amended so that supervising physicians can be "compensated for the PAs' work that is carried out under delegation, with or without the presence of the supervising physician" (OMA, 2009, p.5). Certainly, the sustainability of these costs to the health care system and to society would need to be considered.

CAPA has recommended that the MOHLTC provide transitional funding to the CPSO so that the cost of PA regulation does not become a burden to physician members. The specifics of these costs are not detailed in the application.In the absence of verifiable cost-effectiveness data, it is the position of NPAO that CAPA has not met the economic criterion.

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

In order to determine the impact of the introduction of PAs from a health human resource perspective, one would first need to revisit the intended reason PAs were introduced 4 years ago for the civilian population of Ontario. NPAO was unable to locate a specific needs assessment which speaks to this intent, so various reports and articles were examined instead.

Some reports indicate that PAs were introduced in response to a physician shortage in Ontario (CPSO, Tackling the MD shortage, 2004). According to a recent report by the Ontario Medical Association, the physician shortage has been significantly reduced with increased growth in the number of medical graduates as well

as a reversal of the so-called "brain drain" (Kraj & Kantarevic, OMA, 2012). A report by the CPSO states that the physician supply has increased by 20% since 2000, adding almost 4000 new MDs to Ontario's supply. (CPSO News Release May 10, 2011). Between 2008 and 2009 (as the PA demonstration project began) the national supply of physicians increased by 4.1%, more than triple the rate of growth of the Canadian population as a whole (CIHI, 2010). The problem of the "orphaned" patient has also been addressed. As of 2010, approximately 10 million of Ontario's 13 million population had rostered or enrolled with about 7,900 primary care physicians (Kraj & Kantarevic, OMA, 2012).

Other reports indicate that PAs have been introduced in order to provide a practice opportunity for Internationally Trained Medical Graduates (IMGs). However, now that there are more government-funded residency positions in medical programs reserved for IMGs, IMGs are choosing to pursue their license to practice medicine rather than pursue a career as a physician's assistant. According to the CPSO, in 2010 more licenses to practice medicine were issued to IMGs than to Ontario graduates, a trend that is continuing (CPSO, May 2011).

At a recent forum hosted by McMaster University entitled "The Expanding Role of Non-Mds in the Canadian Health Care System" (March 20, 2012), Dr. John Cunnington, Assistant Dean, Physician Assistant Education Program, described the role of the physician assistant as follows: "It is quite simple. It is to be the assistant to the physician." Dr. Cunnington emphasized that the supervising physician stays in charge of the patient and their care and they delegate activities as needed so that the physician may see more people. He noted that physician assistants are different than nurses in that they are trained in the medical model taking some of the very same courses that medical students take as opposed to nurses who are trained in the nursing model.

It is the position of the NPAO that if physicians require well educated and capable providers to assist in the care of patients, they should look no further than the large cohort of highly qualified, self-regulated nursing professionals in Ontario. According to the College of Nurses of Ontario, there were more than 150,000 RNs, RPNs, and NPs registered in Ontario in 2011 (www.cno.org). Nursing's scope of practice is well defined: "The practice of nursing is the promotion of health and the assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function." (Nursing Act, 1991) [from Legislation and Regulation: RHPA: Scope of Practice, Controlled Acts Model, revised 2011]

Under the RHPA, RNs and RPNs are authorized to 1) perform a prescribed procedure below the dermis or mucous membrane; 2) to administer an injection by substance or inhalation and 3) to put an instrument, hand or finger into a bodily orifice. RNs and RPNs may perform the aforementioned controlled acts if it is ordered by a physician. NPs have authority to initiate and perform these and other controlled acts independently. It follows logically that there are more than 150,000 nurses in Ontario able and willing to help provide necessary services to the population, either through delegation or independently Furthermore, nursing adds an important element to the provision of client care: a focus on the client's perspective and the client's experience of their condition.

In the absence of verifiable evidence, NPAO is unable to comment on the impact that PAs have had on patient outcomes such as quality and safety and on their impact on the health-care system in Ontario. Much of the literature reported in the HPRAC Literature Review refers to the impact of mid-level providers, research which lumps PAs in with NPs. The article by Ducharme et al. (2009) is an example of this type of research. The unique contribution of NPs has already been well established. In RCTs and meta-analyses, NPs have consistently shown that they provide safe, high-quality care with excellent patient outcomes. The challenge is now to evaluate the distinct role of the PA in Ontario.

7. Do you have any other general comments?

In future, it would be helpful to have a better understanding of the projected role of PAs in Ontario within the broader healthcare landscape . CAPA states that the goal of PAs is to "supplement rather than supplant physicians". At the same time, it would seem that PAs desire to work more autonomously and independently rather than at the side of and on behalf of a supervising physician.

The following excerpt exemplifies this desire to be seen as autonomous providers; the excerpt is from the main page of the CAPA website (March, 2012):
"With the recent announcement that Balcarres is to lose its only physician, perhaps it is time to reconsider utilizing physician assistants in this province to alleviate physician shortages in rural Saskatchewan.
Physician assistants can perform a wide range of procedures including conducting patient exams, ordering diagnostic tests, undertaking minor procedures, taking medical histories, making a diagnosis, treating illnesses, counseling on preventive health care, assisting in surgery and, in some jurisdictions, writing prescriptions. Physician assistants have been utilized in the military for many years. They are recognized in our border provinces, Manitoba and Alberta, but not in Saskatchewan. They can work in a rural community where there is no physician, and can be supervised by a physician from another rural community, fortunate to have a physician. Perhaps it is time."
Read more: http://www.leaderpost.com/health/Cure+shortages/6188505/story.html#ixzz1qFvneXmA

At this point in time, PAs are working under medical directives and under direct physician orders. But typically, professions seek to be regulated partly in order to gain independent authority to initiate some or all of the controlled acts under the RHPA. In their current application, it is not entirely clear which of the controlled acts CAPA is seeking to access at this time. For example, CAPA states that PAs are now permitted to write prescriptions, including prescriptions for narcotics, under delegation. The authors of the application express frustration that there have been many instances whereby a prescription written by the PA was questioned and/or delayed while the pharmacist waited for confirmation that there was indeed a medical directive and/or sought an MD as cosignatory The CAPA application recommends that PAs should be able "to write prescriptions somewhat independently" (p19). Clarification of the PA role would be important information to help project the future supply and demand of physicians and other health human resources.

Thank you for the opportunity to provide input into this process.

The Nurse Practitioners Association of Ontario

Respondent: Ontario Physiotherapy Association

1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?

The Ontario Physiotherapy Association (OPA) has reviewed the Canadian Association of Physician Assistants' (CAPA) Application for the regulation of Physician Assistants (PA) under the Regulated Health Professions Act (RHPA). We acknowledge the extensive work that has gone into this process and thank CAPA for providing clarity on the role and responsibilities of this new profession in Ontario. Physiotherapists have had the opportunity to work with our physician assistant colleagues in many settings in the health system in Ontario and through the Canadian Forces and value their contributions to interprofessional care.

In responding to the questions posed by HPRAC in the consultation phase, the OPA considered all aspects of the application including the current systems in place to ensure public safety.

As stated frequently in the application, Physician Assistants work under a delegation and supervision model with individual physicians and are subject to indirect regulation by the CPSO under the Medicine Act, through the regulations, standards of practice, guidelines and policies that now govern physicians. It is the individual physician who evaluates the competencies of the PA and articulates the conditions under which the PA will perform delegated and assigned acts. There is no suggestion in this application that this would change with regulation under the RHPA.

Though the risk of harm is inherent in the controlled acts that the PA performs under delegation, the application from CAPA clearly states that PAs are not seeking authority to self initiate any of the controlled acts and wish to continue under a delegation and supervision system:

'The nature of the (PA) practice is entirely dependent on the practice of the physician(s) with whom the PA is associated.' [Page 6 of Application.]

'Every act performed is by agreement with the physician. Every act performed is one delegated by a physician.' [Op. cit.]

'No activities are exclusively performed by a Physician Assistant.' [Page 8.]

Under 'Risk of Harm', in the section entitled 'Public Safety and Regulation', CAPA states clearly that it is the responsibility of the physician to appropriately delegate and supervise. This clearly suggests that it is more critical that the regulatory system for physicians be used to ensure those roles are fulfilled in the public interest.

For these reasons, the OPA does not believe that CAPA's Application has met the threshold of harm requirement, nor has CAPA explained how the public interest would be better served by regulation as a profession under the RHPA through the CPSO, compared to the current form of regulation of PAs by the CPSO under the Medicine Act through regulations, standards of practice, guidelines and policies that govern physicians' interaction with PAs. In addition where PAs practise in hospitals and long-term care homes, examples provided by CAPA show that the current system of medical directives and supervision under a physician adequately protects the public.

In its application CAPA indicates that statutory title protection is needed for public protection:

' Regulation would prevent those who pose as PAs and possess adequate training or supervision from holding themselves out as PAs and thereby deceiving patients.' [Page 9]

The OPA notes that title protection linked to minimum credentials administered by the Association or some other body could achieve this objective much more cost- effectively than RHPA regulation. In fact, the example under Appendix C (the Bylaws of the College of Physicians and Surgeons of Alberta) is a clear demonstration of this.

Requirements to be listed on a registry or roster could also include minimum professional liability insurance and minimum educational requirements.

2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?

As noted in Question 1, the OPA believes that PAs are now regulated, though indirectly, by the CPSO under the RHPA. Since, by the nature of the profession, all practice will continue to be delegated, supervised and dependent on the evaluation by and in partnership with an individual physician, the OPA would argue that this is the most appropriate level of regulation for the profession in the public interest.

As previously mentioned, title protection and adequate certification, can be achieved through other means that could also allow the profession to continue to evolve without the need for legislative changes that may become a barrier to development, as they sometimes have under the RHPA for other professions as they develop and evolve.

3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.

The OPA believes that this is the crucial question in this review.

In reviewing the application, the OPA is not convinced that the current models of regulation, namely delegation, supervision, medical directives and protocols, or some combination thereof, are insufficient to address the risk of harm inherent in the practice of the profession. Those models of regulation are used routinely to enable a range of unregulated practitioners to perform controlled acts and there is no evidence that the public interest or public safety has been imperiled as a consequence.

In fact, in the application it is noted frequently that delegation and supervision would continue under the proposed regulation of PAs and, therefore, it is unclear what additional protection by implementing CAPA's recommendations would be achieved. As noted previously, title protection, requirements respecting educational levels, competencies and certification can be achieved in other, more cost-effective ways.

4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.

Some form of regulation is appropriate, though whether that occurs as proposed, or as per the status quo the fact remains that the profession is defined by and is entirely dependent on the relationship with physicians. If, as appears to be the case that PAs are to continue for all intents and purposes to be under the supervision of physicians, the most effective regulatory approach is to focus on physicians i.e. regulate the supervisor not the supervised.

5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.

We are uncertain as to what would actually change in a practical sense as a result of adopting CAPA's proposal. The proposal seems at least to imply that regulation as proposed in the application would have little or no impact on practice patterns.

We do note the concern of CAPA regarding the cost of implementing regulation for the profession and the request for transitional funding or employer support for registration fees. This may be due to the small number of the profession, but brings up the question of sustainability as a regulated profession under the RHPA.

6. From your perspective, does the applicant convincingly demonstrate the extent of the impact by which the regulation of Physician Assistants will have on Ontario's wider health system? You may wish to comment on such issues as inter-professional collaboration, labour mobility, access to care, health human resource productivity and health outcomes.
The theme of the Application is that implementation of CAPA's proposal would largely perpetuate the status quo in terms of the profession's impact on the health delivery system. RHPA regulation would assist, however, in inter-jurisdictional professional mobility, at least with those jurisdictions where Physician Assistants are regulated. Formal regulation by the CPSO would also assist the CPSO and the Ministry in health human resources planning (subsection 2.1 Health Professions Procedural Code).
7. Do you have any other general comments?
The OPA would like to offer two additional observations: a) At numerous points in its Application, CAPA notes that PAs have only a four-year history in Ontario and states that the Physician Assistants' practice is 'fluid', 'evolving' 'changing rapidly' and that there are 'few practice types that are fully developed'. To the OPA this begs the question as to whether this is an appropriate time to set the regulatory status of and model for Physician Assistants, particularly in light of the fact that statutory and regulation changes take so long to make. It may perhaps be advisable to wait until the profession and practice patterns mature before the regulatory model is formalized to the extent proposed. b) There are many 'assistant' professions involved in Ontario's health care delivery system, such as physiotherapy assistants, medical laboratory assistants, nursing assistants, dental assistants and so on. Historically, there appears to have been a consensus that assistants need not be regulated under the RHPA because delegation and supervision is sufficient to protect public safety. The application for the regulation of dental assistants and now this application obviously have the potential to change that paradigm. If that happens, there will doubtless be a multiplication of the number of 'assistant' professions that will be encouraged to seek regulation. Careful consideration should be made as to whether these professions should be regulated under the RHPA or remain regulated through the standards, policies and bylaws of the professions they assist. Public protection and clarity to the public of competencies and practice have been maintained under the later without the additional expense brought on by regulation under the RHPA. We thank the Canadian Association of Physician Assistants for the Application and HPRAC for this opportunity to review and comment.

Respondent: Registered Practical Nurses Association of Ontario
1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?
Physicians Assistants (PAs) practice under the supervision of the physician, with physician accountability for the outcomes of the work of the PA. Physicians delegate the work of PAs and the PA cannot carry out any acts without agreement by the physican. Since the physician oversees PA practice, agrees to assume

this accountability, and is paid for his/her oversight of the work of the PA, it would seem unreasonable for this category of care provider to require regulation. However, should in the future, there be mounting evidence of a risk of harm to patients through PA practice, The Registered Practical Nurses Association of Ontario would consider supporting the regulation of PAs in Ontario.
2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?
We do not believe that the applicant has convincingly demonstrated a need for regulation. There is no demonstration of complaints and disciplinary actions are not included in this application. As well, the oversight by the physcian appears to be meant to protect the public from any harm that may result from engagement in controled acts (through the delegation process).
3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.
The practice of the PA is meant to be delegated and supervised by the physician and this has been described as sufficient at the inception of the PA role. These existing mechanisms should be adequate to address the risk of harm. This does not preclude a concern by RPNAO that PAs may possibly work outside the terms of employment and the knowledge, skill and judgement of this role.
4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.
No. There doesn't seem to be any evidence that physician assistants practice from a defined scope of practice because, in fact, the scope of their work is defined by the practice of the physician who delegates their work. It is also unclear if PAs have a defined or common body of knowledge. Therefore expectations for the role and responsibilities of the PA can only be confirmed on an individual basis and not in terms of an autonomous role.
5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.
The very small number of PAs in Ontario would suggest that it would not be practical, feasible, or cost effective to implement regulation at this time. Given that Ontario has a highly effective and more affordable primary care provider in Nurse Practitioners, it would seem the regulation of PAs would be a costly investment without sufficient evidence of added benefit to patients.
6. From your perspective, does the applicant convincingly demonstrate the extent of the impact by which the regulation of Physician Assistants will have on Ontario's wider health system? You may wish to comment on such issues as inter-professional collaboration, labour mobility, access to care, health human resource productivity and health outcomes.
RPNAO believes that the applicant has not convincingly demonstrated that regulation would provide a positive impact on access to care, collaboration or health human resource productivity. As for health outcomes, there would seem to be ample evidence to suggest that an ongoing investment in Nurse Practitioners would provide for the best improvements to access and quality health outcomes.

7. Do you have any other general comments?

Respondent: St. Joseph's Healthcare
1. In your view, does the applicant meet the 'risk of harm' threshold? In other words, has the applicant demonstrated that Physician Assistants pose a risk of harm to the health and safety of the public if the profession is not regulated under the RHPA?
While the application did not articulate this well in our opinion, the risk of harm to the public is primarily related to the confusion regarding scope of practice for the Physician's assistants and role within the health care system. From the Health Professions Regulatory Advisory Council application document, it states that "every act the physician is competent to perform him or herself can be delegated to the physician assistants they are working with." It is logical then, if a physician needs to be regulated to perform their work, a physician assistant would also require regulation. Regulation would provide assurance to the physician that he/she is delegating a responsibility to an individual who has educational standards to support their practice. The variability of role and scope of practice from the supervisory model creates risk to the public. The assignment of tasks that varies from physician to physician leaves the interpretation wide open as to what acts a physician assistant can perform. The scope of practice of physician assistants should clearly delineate the difference between physicians and physician assistants. There needs to be a general description of acts a physician assistant can perform. It was felt that the practice of the supervisory physician to evaluate the individual physician assistant's abilities and delegate procedures and services which are appropriate on an individual basis, was a source of great confusion and potential misunderstandings. Based on the education and training of physician there needs to be a defined scope of practice established for the profession. From a practical perspective, other healthcare professionals need to have a clear awareness of what colleagues are able to do on a consistent basis otherwise the processes of care, issues related to patient flow, and accessibility of care will be delayed. For example, if the supervising physician can carry out a complex complicated procedure for a type of patient today but the supervising physician tomorrow does not treat that specific patient population and does not have the competency to carry out that procedure but this patient needs it other healthcare professionals will be confused as to why or why not the PA is acting on this one day but not the next in similar situations especially if that other professional is able to initiate or carry out the activity because it is within their defined scope of practice or is approved as a task that they can do if ordered by a physician. This lack of clarity is confusing for health care providers and in turn would be very confusing for the public.
2. In your view, has the applicant demonstrated convincingly that it is in the public interest that Physician Assistants be regulated under the RHPA?
Yes. To ensure public safety and quality care, St. Joseph's Healthcare Hamilton supports the need for regulation of Physician Assistants under the Regulated Health Professionals Act, aligned under the College of Physician and Surgeons of Ontario. Regulation provides an important mechanism for the development of practice and educational standards as well as for disciplinary action consistent with other regulated healthcare professionals. We strongly support the need for Regulation to ensure public safety.

It is very important for this profession to be regulated to ensure that standards can be upheld and that individuals of this discipline will be accountable for their work. Regulation will allow members of the public to have a vehicle for complaints if there is a problem. The requirement that PA's be required to write the PACCC PA certification exam in order to have the CCPA designation was also thought to ensure the entry to practice standards.

3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation.

There was some partial argument to support this, however, as previously articulated in section 1, the variability of role and the lack of clarity regarding scope of practice results in role confusion and puts the public at risk. Again, this is what we view to be the greatest risk of not being regulated. This concern is not adequately addressed by the current mechanisms that are in place. All stakeholders would benefit from the clarification of role and the implementation of standards to support interprofessional practice.

The practice leaders felt that the role of the PA was interdependent with that of the physicians and, therefore, the discipline would not need to have any specific controlled act as they would always be delegated. Pharmacy felt that variability in the prescription controlled act as described based on setting and practice expertise , while improving the ease of the work of the PA, was a practice of significant enough risk that a co-signature should always be required with a clear directive in place. The collaboration between the colleges including pharmacy was critical to ensure patient safety.

4. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is appropriate for the profession? You may comment on issues such as body of knowledge and scope of practice, education requirements etc.

We believe this it true. We continue to want to emphasize the benefits of a defined scope of practice. The professional practice disciplines that responded were very specific that the definition of the PA scope of practice needed to be clearly defined to ensure appropriate practice in multiple settings and ensure role clarity. The Canadian Association of Physician Assistants consistently describes them as “highly skilled healthcare professionals, educated in the medical model, who possess a defined body of knowledge to carry out clinical and procedural skills, interpret diagnostic information, complete investigations, make clinical decisions and carry out diagnostic and therapeutic therapies. The PA has the skills and experience to deal with everyday healthcare needs for patients in various specialty practices environments. (P6)”.

CAPA already acknowledges that their scope of practice is continuing to expand; but does not specify any particular practices nor to what level or complexity of patient population. CAPA appreciate that “PAs are carrying out important, necessary, and potentially high-risk activities (p11).” However, these are actually controlled acts that they are completing under delegation from the physician. Without a defined scope of practice and this subsequent dependency on the Physician‘s scope of practice, they cannot sub-delegate a task or controlled act to another healthcare professional.

Without a defined scope of practice, other regulated health professionals are unclear as to what activities PAs are permitted or what controlled acts may be a carried out when working with a variety of physicians whose specific competencies maybe unknown to the collaborating health care provider (Nurse, OT, SLP, PT RT) .

It was also expressed that the scope of practice needs to be established for the profession so it is clear to other health care professionals working with physician assistants and to patients what they can do. The application states that the physician assistants practice is evolving and changing rapidly which is another reason

that in order to ensure patient safety there should be a defined scope of practice for physician assistants. Clarity is a key requirement in the development of the scope of practice of physician assistants as well as how any potential overlap in scope is communicated with other healthcare professionals

Thus, we strongly advocate for a clear definition of scope of practice to facilitate role clarity. Without a clear ability to articulate their area of expertise and contribution, the public will fail to appreciate their role in their healthcare, which can lead to under utilization or over expectation.

Having reviewed the core competencies as per the CAPA document, and the various academic programs, we offer consideration be made to adopt the Manitoba model. Through the documents they speak about the highly trained, skilled health care provider but the Ontario model speaks to a 4 year program with only 2 years focused on the PA role and implementation leading to a Bachelor's degree that trains them as generalist to function at the level of clinical clerks. The Clerkship phase leads to the actual training of the medical professional that then takes 2-7 years. Clerks are not managing significant caseloads of complex, sick patients with multiple chronic diseases while navigating the challenges of the current Canadian Health care system, in an effort to support families in crisis under variable levels of supervision.

The Manitoba model is at the Graduate level so students bring prior learning and knowledge to the study. The Ontario requirements do expect student to have some health care background amounting to 1650 hours but this is quite vague and thus variable along with academic pre-requirements in sciences. Our current pool of PAs have demonstrated significant advanced preparation than this but consideration should be given to future applicants as this becomes a viable career choice for students applying directly from Secondary school . Of note, this is significantly less formal study than other regulated health professionals but with substantial direct impact on the health and safety of patients by virtue of their role as the Physician assistant.

5. In your view, does the applicant convincingly demonstrate that regulation under the RHPA is practical to implement for this profession? You may comment on issues such as economic implications and members' commitment and ability to support the costs and development of statutory regulation.

In their submission, they spoke about the benefits of the role in relation to improved access to the physician care model but did not fully explore the cost /benefits to their members through the requirement for regulation . Initially there may be a high burden of cost associated with the establishment of a professional college given the existing small numbers of potential members. The cost benefit may need to be weighed at this time.

Through regulation, there is a quality assurance program requirement that is the responsibility of the individual health discipline not the province which they would be expected to comply with once regulated. It was felt that the requirement that PA's be reimbursed for certification costs is not a right shared by other health disciplines regulated by this legislation and would therefore not be supported by these professions.

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

There was some concern related to the newness of the profession and the appropriateness of the role within the Canadian public health system. There was also some queries regarding the evaluation of the impact and effectiveness of the role in Ontario before proceeding with a formal regulation to ensure we are regulating a viable profession.

Much work has taken place previously through HPRAC as articulated in the document “An interim report to the Minister of Health and Long-Term care on Mechanisms to Facilitate and support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals: Phase II ,Part 1” to ensure consistent standards and scopes of practice are developed and maintained with appropriate checks and balances to protect the public . Overlapping scopes of practice require collaboration between the individual healthcare professionals and their respective colleges while retaining the independence of each of the regulatory professional body. This discussion cannot take place until the PAs are regulated and can articulate their scope of practice.
7. Do you have any other general comments?

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