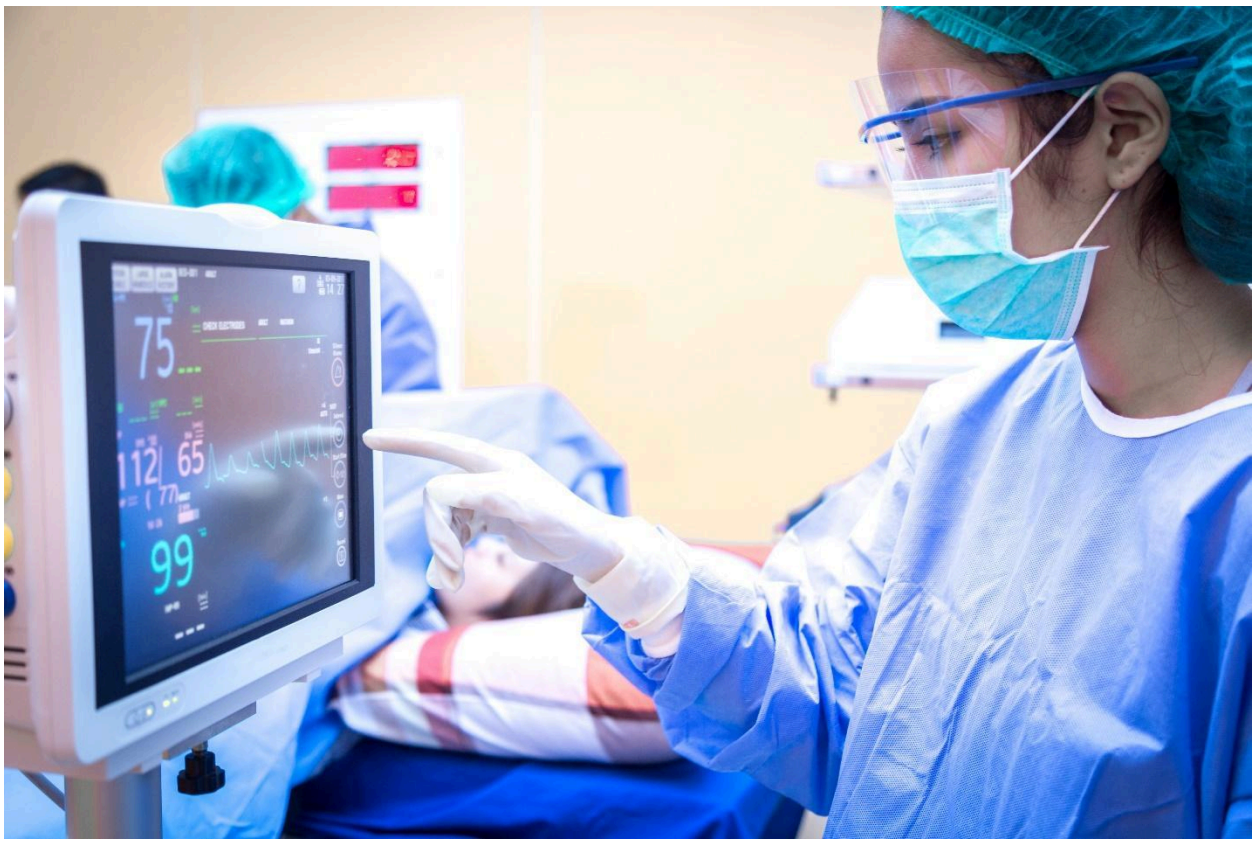
Regulation of the Clinical Assistant Occupation in Ontario

Joint Position Paper



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About the Internationally Trained Physicians Access Coalition (ITPAC)

The Internationally Trained Physicians Access Coalition (ITPAC) is an alliance of internationally trained physicians (ITPs), advocacy organizations, as well allied groups/organizations providing support and programming to ITPs. The coalition's work includes the identification of systemic barriers ITPs face as they navigate entry and progression into their profession in Canada. The Coalition also promotes enduring healthcare systems solutions that benefit all residents of Canada, while ensuring a high standard of healthcare.

This paper was jointly developed by the following ITPAC members:

1. Association of International Physicians and Surgeons of Ontario (AIPSO)
2. Community Matters Toronto
3. Internationally Trained Medical Doctors Canada Network (iCaN)
4. Internationally Trained Physicians of Ontario (ITPO)
5. Niagara IMGs/IENs Support Group
6. The International Doctors' Network (IDN)
7. WIL Employment Solutions
8. World Education Services (WES)

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1. Introduction / Current Context

Both the Physician Assistant (PA) and Clinical / Clinical Surgical Assistants (CA) occupations are growing professions in Canada. Both PAs and CAs play a key role in supporting the capacity of health systems across Canada by supporting patient care, enabling cost-savings, and providing access to quality healthcare by acting as "physician-extenders". The Winnipeg Regional Health Authority distinguishes between PAs and CAs as "distinct roles with many overlapping functions."

In Alberta, Nova Scotia, and Ontario, internationally trained physicians (ITPs) are specifically targeted to the CA profession. Emerging evidence suggests that ITPs are increasingly employed as CAs in Ontario, many leveraging the position as a stepping stone to medical licensure. Many ITPs employed as CAs also face significant issues related to scope of practice and job quality.

In 2021 the Ontario legislature introduced Bill 283, Advancing Oversight and Planning in Ontario's Health System Act, 2021 ("Bill 283"; see Appendix A). Schedule 3 of the legislation establishes "Physician Assistants" as an occupational group that would come under the regulatory authority of the College of the Physicians and Surgeons of Ontario (CPSO). However, Bill 283 did not address the CA occupation.

As the CPSO, Ministry of Health & Long-Term Care, the Office of the Fairness Commissioner, educational institutions, and other stakeholders work to develop and implement a regulatory package for the Physician Assistant profession, it is imperative that consideration be given towards implications for an adjacent and overlapping occupation of Clinical Assistant, and the significant number of ITPs with international medical training and experience who are employed or seeking to become employed in these professions in Ontario.

2. Recommendation

Under Bill 283, PAs in Ontario are subject to the current delegation model of care delivery in accordance with the Regulated Health Professions Act (RHPA); 1991 Chapter 18 Section 28 which allows for 'Delegation of Controlled Acts'. Under the delegation model, PAs may operate in a health care setting only under the delegated authority of a licensed physician and within a prescribed set of duties or functions. Under professional regulation, PAs in Ontario would also be subject to a defined entry to practice criteria and continuing education requirements.

ITPAC recommends that the professional title of "**Clinical Assistant**" be established in addition to the title of "Physician Assistant" in Ontario. Specifically:

A. Establishment of the title of **"**Clinical Assistant" as an additional regulated health profession that falls under the CPSO (Limited Practice License), with:
    a. Defined entry to practice criteria
    b. Scope of practice determined under the same delegation model of care delivery as PAs, aligned with the RHPA
    c. Approval of CA positions to qualify as evidence of recency of clinical practice for Internationally Trained Physicians

3. Why regulation of the CA occupation matters to ITPs in Ontario

There are several issues that impact ITPs working as CAs in Ontario, which support the rationale for professional regulation of the CA title. These include:

Regulatory issues	Issues with job quality
(i) Variation in scope of practice for CAs (ii) No opportunity to retain recency of clinical practice as a CA (iii) Limited pathways to independent medical licensure	(iv) Poor job quality and employment conditions for CAs in Ontario (v) Substandard compensation for ITPs employed as CAs

A brief discussion of each issue follows:

(i) Variation in scope of practice for CAs in Ontario

In Ontario, PAs currently work in accordance with the Regulated Health Professions Act (RHPA); 1991 Chapter 18 Section 28 which allows for 'Delegation of Controlled Acts'. This mechanism allows a health professional (such as a licensed physician who is authorized to perform controlled acts) to temporarily grant that authority to another person who is not licensed or legally authorized to perform the act independently. This delegation model is used in other provinces that regulate the PA profession.

The CPSO policy on Delegation of Controlled Acts includes language specific to internationally trained physicians (or "IMGs", International Medical Graduates) working as PAs, who have licenses in other jurisdictions but are not registered in Ontario:

> *The same protocols that apply when delegating to any other individuals apply to IMGs. In particular, physicians cannot rely exclusively on credentials or licenses obtained in other jurisdictions to ascertain whether an IMG has the requisite knowledge, skill, and judgment to safely perform a controlled act and must be equally diligent in evaluating and establishing the IMG's competence to perform the controlled acts as they would for any other delegate.*

Currently, ITPs employed as CAs in Ontario also work under this delegation model, but in a highly unregulated setting. In contrast to the PA profession, which has a PA National Competency Profile, there is no defined national competency profile for CAs, resulting in significant variation in scopes of practice between employment positions for CAs.

As a result, ITPs employed as CAs in Ontario work in numerous healthcare settings under varied conditions and requirements. This includes

- varying levels of responsibility
- differences in the number of hours of patient contact
- variations in required specialized clinical skills

- differences in the clinical scope of practice that is determined by the relationship with the supervising physician

Some ITPs employed as CAs perform janitorial, administrative, and nursing/personal care tasks.

While this diversity of duties speaks to the versatility and broad value of ITPs' skills and training, the extent of variation also highlights the need for clear, defined scopes of practice that can properly utilize ITPs' range of existing medical competencies, ensure workplace fairness and equity for all CAs, and increase the efficacy of Ontario's health systems.

(ii) Limited opportunities to retain recency of clinical practice as a CA

Demonstrating recency of clinical practice is a requirement to obtain and maintain medical licensure in Canada. For ITPs there are very limited opportunities to obtain clinical experience, which is needed to apply for residency positions or placements through the NAC Practice-Ready Assessment (PRA) program.

For example, in Ontario, ITPs may obtain recency of practice through the Graduate Diploma in Medical Sciences (GDPM) program through Queens University, or by securing one of a very few Restricted Licenses as a Clinical Fellow through the CPSO. Neither option provides adequate opportunities for the numbers of ITPs in the province.

For ITPs determined to advance their medical careers, many choose to travel between Canada and their country of origin, at great personal and financial costs, in order to practice medicine for a short period of time and thus retain recency of practice that can briefly/temporarily maintain eligibility for CaRMS and/or Practice Ready Assessment placements.

(iii) Limited pathways to independent medical licensure

In addition to passing relevant Canadian examinations and demonstrating recency of clinical practice, factors relevant to ITPs securing a residency match via the CaRMS or a Practice-Ready Assessment (PRA) placement[1] include:

- introduction to and experience in the Canadian health system and
- A minimum of 3-4 reference letters from licensed Canadian physicians

To meet these criteria, ITPs working towards full medical licensure must search for clinical placements, which can be obtained through employment as a CA. ITPO survey results have revealed that some unscrupulous employers have required ITPs to pay training fees to secure these positions.

Because a large portion of medical residency training occurs in hospital settings, experience within the Canadian health system for ITPs can only be considered comprehensive if opportunities exist to practice as a CA in both community and hospital settings. Currently in Ontario, only a very small proportion of ITPs employed as CAs are employed in a hospital setting.

[1] The NAC PRA is not currently offered in Ontario; ITPs seeking medical licensure through this route must apply to one of the 7 provinces where it is offered.

ITPAC is advocating for the establishment of Clinical Assistant as a regulated occupational title. This would both promote improved regulatory accountability of the occupation and serve as a much-needed additional pathway to medical licensure for ITPs in Ontario by providing opportunities to gain exposure to the Canadian health system and establish professional relationships with appropriate referees.

(iv) Poor job quality, job security, and employment conditions for CAs

ITPs employed as CAs in Ontario experience issues with job quality and have limited clinical practice opportunities in hospital settings. In Ontario, it is common for both PAs and CAs to hold multiple part-time positions through contracts. This same workplace structure of multiple part-time contracts also exists for Personal Support Workers (PSWs) and nurses in the homecare/long-term care sector, which has proven to be disastrous and deadly in the context of a pandemic.

Job security for ITPs seeking medical licensure is also compromised by the need to travel frequently to maintain recency of practice through, for example, costly externships in the United States. This hampers the quality and consistency of care that ITPs could provide as CAs if the need to travel internationally were reduced or eliminated.

In contrast to PA profession in Ontario, where integration is funded through the PA Career Start Program[2], there is no established mechanism to provide dedicated funding for the integration of CAs in health settings. Regardless of practice setting or models of funding, unpredictable funding increases the risk of turnover and job insecurity.

(v) Substandard compensation in relation to skill requirements for ITPs employed as CAs

Variation in terms of professional regulation and government funding models contributes to inconsistencies in remuneration for PAs and CAs between provinces. In Ontario, neither PAs nor CAs have established salary scales for remuneration/compensation. Medical institutions (e.g. clinics, hospitals) establish their own wage rates on the basis of labor market information, which frequently leads to low wage rates for ITPs employed as CAs.

The majority of ITPs employed as CAs in Ontario earn less than $20 per hour (CAD) and, remarkably, some ITPs report being unpaid in their CA positions. Popular job listing platforms show a range of approximately $15 - $20/hr. for CAs in Ontario, with a low of $14 per hour and an average of $18 - $19 per hour.

These rates are significantly lower than in other provinces, including Alberta, which has an established pay scale beginning at $32 per hour (probationary period), increasing to $45 per hour upon completion

[2] Funding for PA integration in Ontario is described as "a patchwork of different mechanisms" that depend heavily on individual contexts (e.g. the physician's funding model, access to provincial grant programs). Currently, the provincial Ministry of Health provides funding to family health teams (FHTs), Community Health Clinic (CHCs) and other primary care models to hire PAs through the PA Career Start program, which provides grants of up to $46,000 per year to employers, for two years. Additional funding may come from physician salaries.

of probation, and increases again with subsequent increments over time to a maximum of $80 per hour. CAs in Manitoba have a salary scale that is negotiated collectively between Physician and Clinical Assistants of Manitoba (PCAM) and regional health authorities.

Pursuit of medical licensure for ITPs in Ontario requires a significant sum of money and time. Stable and commensurate employment is a key component for ITPs to be able to progress in their careers, support themselves and their families, and achieve financial stability while in pursuit of independent licensure. Through commensurate employment, the province in turn reaps the social, health and economic benefits of having medical professionals that can rebuild and diversify the healthcare talent pool.

4. Recommendations: Regulatory and Job Quality

In several Canadian provinces, including Alberta, Nova Scotia, and Ontario, ITPs are specifically targeted to the CA profession. In Nova Scotia and Alberta, the CA occupation is regulated, and ITPs receive the benefits of a defined scope of practice and higher job quality, including remuneration.

In a highly unregulated environment in Ontario, however, the existing structures of recruitment and employment for CAs fall short for ITPs in several areas. This includes:

- an ineffective use of ITPs' medical training and experience
- a failure to provide meaningful pathways for career progression
- a contribution to de-skilling of ITPs

ITPAC proposed the following recommendations that can address regulatory issues affecting ITPs employed as CAs, and improve job quality for CAs in Ontario:

Regulatory issues	
Recommendation	**Benefits**
1. **Establish** appropriate entry to practice criteria for the "Clinical Assistant" occupation and Limited Practice License under the CPSO that account for: a) Academic credentials (obtained domestically or abroad) b) Relevant qualifying medical examinations c) Relevant clinical experience (supervised and unsupervised) d) Alignment with registration/entry to practice requirements in other Canadian provinces	• Defines and standardizes educational / training requirements for CAs in Ontario, ensuring high standards of care and public safety • Potential to align eligibility criteria with successful models of CA registration in other Canadian jurisdictions (Manitoba, Alberta, Nova Scotia)
2. **Establish** a defined scope of practice for "Clinical Assistant" registration class that operates under a delegation model of care as per existing language in the Regulated Health Professions Act (RHPA).	• Improves consistency between scopes of practice for CAs in Ontario • Ensures full use of ITPs' existing medical training and competencies • Facilitates alignment with other Canadian jurisdictions (both the OMA & CAPA support

	interjurisdictional alignment under a delegation model)
3. **Approve** employment as a CA as recency of clinical practice with provision of official documentation which can be used as recency of practice in support of residency placements through CaRMS or licensure through the NAC PRA.	• Streamlines processes related to securing medical licensure for ITPs • Increases opportunity for ITPs to retain recency of practice in Canada, reducing personal and financial burden of travelling internationally to retain recency • Can lead to reduced instructional times, less use of orientation resources and acclimatize/acculturates ITPs to clinical settings (and vice versa)

Issues of job quality for CAs in Ontario	
Recommendation	**Benefits**
4. **Establish** a centralized body within Ontario Health to facilitate planning and coordination between stakeholders involved in CA integration in different health settings (community clinics, hospitals, family health teams (FHTs), Community Health Clinic (CHCs), etc.)	• Centralized system model can enable standardized terms of employment and streamline hiring processes • Coordinated approach can enable cost-savings for stakeholders, including employers • Can help establish strategic CA positions across Ontario, including in regions and sectors with staffing shortages such as Northern Ontario, or the Long-Term Care sector
5. **Provide** dedicated government funding to support CA integration in different health settings, leveraging a similar model to the PA Career Start program	• Improve long-term health and human resource (HHR) planning and improve job quality and job security for CAs • Reduce financial burden to employers seeking to hire CAs in a variety of health settings • Diversifies skills base of healthcare team • Up-front investments to CA integration can support improved access to primary care and thus reduce strain on health facilities through, for

	example, unnecessary or delayed visits to emergency departments (See Appendix D)
6. **Mandate** the implementation of a standard pay scale for Clinical Assistant positions with reference to the PGY-1 of a medical residency program. The PGY-1 salary for Ontario is approximately $32/hour. This can then be increased incrementally over a determined period of years to mirror PGY-2 ($35/hour) and PGY-3 ($38/hour).	• Aligns rates of compensation for CAs with rates of pay for professions with equivalent scopes of practice / clinical requirements within Ontario • Ensures commensurate compensation relative to existing competencies and skills requirements for ITPs employed as CAs

5. Summary:

- Evidence suggests that a significant number of ITPs are currently playing the role of 'physician extender' as Clinical Assistants in Ontario.
- ITPs employed as CAs report significant variations in scopes of practice, limited or no opportunities to retain recency of clinical practice, limited pathways to medical licensure, and poor job quality, including compensation and employment conditions.

Regulation of the CA profession in Ontario would allow the unique and needed skill sets of ITPs to be integrated more effectively into the healthcare system. Using a coordinated approach, integration of ITPs as CAs can improve the functionality of multi-disciplinary healthcare teams, improve access to primary care, enable cost-savings for employers through improved planning, and help reduce unnecessary strain on health services.

Regulation of the CA profession would help to reduce underemployment of ITPs, and create an additional, stable, viable pathway that allows for maintenance of ITPs clinical experience and ultimately facilitate maximal contributions to the healthcare system as fully licensed physicians. Other provinces, including Alberta, have successfully implemented effective models for CA licensing and workplace integration, and ITPAC would be pleased to work with the government, the CPSO, and other engaged stakeholders to ensure the implementation of a practical and productive healthcare delivery model that benefits all Ontarians.

6. Appendices

Appendix A: Overview of Bill 283

Overview of regulatory context for Physician Assistants under Bill 283:

- Establishes a new physician assistant member class under CPSO;
- Creates title protection for "physician assistant";
- Ensures physician assistants cannot use the title of physician or psychotherapist, and are not inadvertently captured in the powers/obligations of a physician in statute outside the Regulated Health Professions Act (RHPA) or the Medicine Act;
- Restricts physician assistants from performing a controlled act unless permitted or in accordance with regulations made by CPSO; and

- Creates a new ground of professional misconduct should physician assistants contravene the restrictions on controlled acts.

Appendix B: Titles, Entry to Practice, and Salary Considerations for Clinical Assistants in Alberta, Manitoba, and Nova Scotia

Province	Title	Entry to Practice / Registration Requirements	Payment Method	Other Considerations
Alberta	Clinical/ Surgical Assistant *	- MCCQE1 - Verified Internship or other PGME	Salary	Considerable additional benefits The ACSAP program is funded and governed by Alberta Health Services. Licensure with CPSA 6 month probation
Manitoba	Clinical Assistant	- Registered Clinical Assistant assessment offered by the University of Manitoba - NAC OSCE - MCCQE2	Salary	- Licensure with CPSM - Two categories of registration: Full practice (family practice or specialty practice), and; provisional registration
Nova Scotia	Clinical Assistant	- MCCQE1 - PGME 1-2 years - Licensed Practice 1-2 years - Recent practice within 5 years	Varied (explore further)	These requirements exclude many ITPs. Licensure with CPSNS Probationary period 12 weeks

Appendix C: Cost- Benefit Analysis for CA Integration

Over the past decade, healthcare costs have continued to rise. The bulk of healthcare cost in Ontario has long been attributed to 2 major costs: hospital admissions and physician compensation. The desire to reduce healthcare costs must always be balanced with the necessity to maintain healthcare quality. Given that Canada already ranks below the OECD average of doctors per 1000 inhabitants at 2.8 to the average 3.5 which places it lower than 9 other OECD countries that are also below average, along with the consistent evidence of inequitable access to care, physician compensation is unlikely to be the area in which cost savings can be gained if quality is to be attained.

Hospital cost however has been partially attributed to high volumes of emergency room visits due in part to poor access to primary care. Reportedly, 42% of Ontarians that visited the emergency room felt they had a condition that could have been treated by their primary care physician if there was access. By having a regulated Clinical Assistant position, that uses the delegation of care model, primary care access can be improved which will in turn reduce the strain on hospitals caused by unnecessary emergency room visits.

The average cost associated with an Emergency Department (ED) visit in Canada (exclusive of physician compensation) is $304.00. In Ontario, there is an estimated 453 visits per 1000 population per year. 42% (190 per 1000 population) of these patients with appropriate access would have visited

their primary care physician. This reduces hospital cost from $137,712 per 1000 population to $79,952 per 1000 population; a cost saving of 42% per year. Further, cost savings can also be gained by less overtime pay. Due to the overload of the ED, ED staff such as unit secretaries are 2 times more likely to work overtime than other hospital staff. ED expenses are about 4 % of hospital costs (in Ontario approximately $800M) and about 64% of hospital expenses (approximately $500M in Ontario) are dedicated to staff compensation (not including physician compensation). In Ontario's ED departments about 5.5% of that cost comes from overtime pay. Properly clearing unnecessary ED visits that can lead to overtime therefore can reduce total staff expense by approximately $30M or 30,000 per 1000 population.

It is understandable why these patients complained of limited access as currently Ontario stands at between 0.6 to 1 family physician per 1000 population. About 30% of Ontarians say they waited too long to see their family doctor. By filling this deficit, we avoid inappropriate ED visits which can result in the cost-savings identified above.

At present 1 family doctor supports 700 patients per 1000 population which is less than ideal since 54% of Ontario family physician describe their job as extremely/very stressful, higher than the Canadian average (45%). This needs to be addressed in the medium term and the excess needs to be supported in the short-term. Through the delegation of care model, the CA position described in this paper gives an economical, short-term solution while simultaneously charting a path toward preparing new physicians that will offer a permanent solution. One can see that such a program promotes sustainability.

One CA can likely help to support the same number of patients given the clinical experience that they already have. These numbers support the addition of 1 CA to assist with primary care per 2000 population. Therefore, 1 CA paid at the level of a PGY-1 resident can make significant headway into the issue of lack of access. This equates to an investment of approximately $30,000 per 1000 to achieve cost-savings of at least $90,000 per 1000 population ($60,000 in inappropriate visits plus (overtime staff cost/1000)).

Another major concern and contributor to the strain on the ED is that patients are coming in sicker. This goes in tandem with an increasing trend of wait times to see a specialist after referral from a primary care doctor. Only approximately 30% of patients reported seeing a specialist within 30 days of referral. Leaving 70% unseen for up to longer than 5 months.

The number of specialist per population has stayed the same as the number of family doctors per population for many years, and is currently at approximately, 1.1 per 1000 population. To decrease specialist wait-time for the other 70% of patients and thus contribute to preventing sicker ED visits, again requires a medium and short term solution; utilize internationally trained physicians in the short term and provide an efficient and effective pathway to licensure for the medium term.

In the five-year period from 2011-2016 approximately 1300 new specialist physicians immigrated to Canada. If this trend continued as it did for the previous two 5-year periods, then as of 2021 there would be 2600 specialist physicians of which an estimated 45% (1,170) would be in Ontario. Combined with the 1,674 new non-specialists, this is an ample workforce that can address these medium and short-term needs.

If current specialist availability can fulfill 30% of referral within 30 days then for a given specialty, 2 CA positions can increase the percentage of patients seen within 30 days to 90%. To understand the potential savings on this we can consider a specialty like cardiology. Undiagnosed chest pain falls in the top 5 ED presenting conditions in terms of hospital cost. Direct patient cost for this is approximately $404 per patient. If 1 CA sees about 300 referred to specialist patients per 1000 population (30%) this may prevent these previously unseen patients from visiting the ED, thereby saving $404 per patient or $121, 200 per 1000 population at a cost of less than half of savings for a CA paid at the PGY-1 level. This program as a medium-term solution to leading towards the necessary additional specialists cannot be overlooked, as Canada ranked last among 11 similar commonwealth countries for specialist wait time.

Appendix D: Potential challenges, mitigation strategies (regulatory issues, job quality)

Potential challenges, mitigation strategies (regulatory issues):

Pushback from Physician Assistants and Nurse Practitioners

The Ontario Nurses' Association has historically voiced concerns and reservations about the integration of adjacent and overlapping health professions into the health-care system, noting similarities between PA, CA, and NP (Nurse Practitioner) roles. ITPAC believes the above recommendations to be complementary in the quest toward the right skill mix. To mitigate against this displacement, or the perception of same, we suggest a wide distribution of CA positions across specialties, healthcare settings (community and hospital) and geography.

Northern Ontario is well known to lack access to healthcare, but 2019 data of Southwestern Ontario shows numerous pockets of inadequate access to primary care as well. In addition, data published in 2020 shows Ontario lagging behind four other provinces in terms of specialist wait time with the median wait time in Ontario being 74.5 days with a 75th percentile of 157 days. All of this despite over 500 PAs and over 3000 NPs currently working. The problem is one of both volume and skill-mix, both of which our recommendations are able to address without displacing other physician extenders or NPs.

Quality Assurance

Maintenance of quality care and the concerns that may surround this are of primary concern for stakeholders and decision-makers. Existing safeguards include completion of the MCC qualifying exams and the NAC OSCE which both Canadian Medical Graduates and International Medical Graduates have to take, but additional actionable mitigation strategies include i) a rigorous interview process, ii) a four-month probationary period and ii) periodic performance assessments.

Potential challenges, mitigation strategies (job quality, job insecurity, multiple contracts):

Coordination among relevant actors

This proposed approach would require coordination among the Ministry of Health for policy and funding, the CPSO for licensing approval and issuing of documentation, and Ontario Health, the Local

Health Networks, and employer associations for operationalization. Other actors include supervising doctors, the CMPA for structuring professional liability and CA applicants.

Such a dynamic and complex endeavor can be best approached through joint planning a matrix project team in which assigned representatives from each acting institution form a project team that develops and implements the initial operation.

Establishing dedicated funding to support CA integration in different health settings

Dedicated funding to support CA positions, including both hospital and community settings, is essential to the success of the centralized model. However, this funding should be viewed as funding to assist and improve the health sector overall through the injection of skilled human capital.

In the short-term, it is estimated that backlog days from the COVID-19 disruption is as much as 75 days per procedure. Ontario is estimated to have to increase the budget by over 20% to clear backlog days. Funding towards increased human capital will go a long way to assist the health system to recover from the impact of COVID-19.

In the long term, funding this program helps to improve statistics such as unequal distribution of access to primary care, lengthy specialty wait-times, and provide tools to assist in more independent physicians that can help improve Canada's below average score of doctors per population amongst OECD countries.