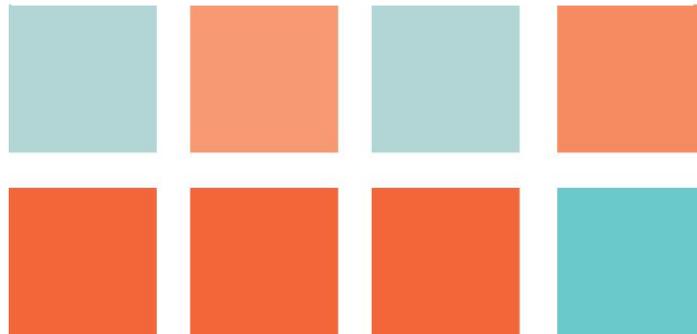


Registered Nurses' Association of Ontario
(RNAO)

Proposal Feedback: Regulation of Physician
Assistants under the Regulated Health
Professions Act

April 2, 2012



- 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? (Please explain the rationale for your position. You may include evidence and/or citations where applicable.)**

There is currently insufficient evidence to assess whether the first criterion, risk of harm, has been met. While the jurisprudence review concluded "the [Physician Assistant (PA)] profession presents a risk of harm to the public" (p.4), the review focused on an insufficient sample of court cases and disciplinary decisions that cannot be generalized and that is of dubious usefulness in the current Ontario context. In fact, care should be exercised before comparing Ontario with other jurisdictions. All cases and decisions were taken from the United States of America (USA), where PAs are already regulated, while none were taken from jurisdictions where PAs are not regulated. According to the Canadian Association of Physician Assistants (CAPA) application, no formal or documented complaints exist with the current use of unregulated PAs in Ontario (p.8).

RNAO recommends that a broader and more representative sample of court cases and disciplinary decisions be investigated. Such a comprehensive review should include the risk of harm -- present or absent -- in the PA demonstration projects which have been implemented across Ontario, as measured by the disciplinary actions or investigations of physicians who have inappropriately delegated and caused harm to the patient. "Every act performed is by agreement with the physician. Every act performed is one delegated by the physician..." (p. 6 of CAPA application) and regulation is not expected to change this fact (p. 18 of CAPA application). In order to determine if there is a risk of harm to the public, the Health Professions Regulatory Advisory Council (HPRAC) must consider the importance of the physician's supervisory role and their complete accountability for the actions of the PA. If physicians provide sufficient and complete oversight, as they are required and paid by the ministry to do, how has the risk of harm to the public become so great as to require their regulation? Ontario evidence of misconduct or malpractice confirms the risk is minimal at best. In fact, keeping PAs unregulated requires greater diligence on the part of the physician to ensure PAs are not acting untoward and endangering their registration; a registration that required 6-8 years of their education to obtain. Given the strict responsibility physicians currently have to monitor the practice of PAs and provide sufficient supervision, RNAO strongly recommends that determination of whether the 'risk of harm' threshold has been met be deferred for at least three years, until adequate evidence is available and a comprehensive evaluation of the PA demonstration projects has been completed.

CAPA recommends in its application that the College of Physicians and Surgeons of Ontario (CPSO) perform the regulatory function during the interim period while evidence is accumulated (p. 22). RNAO disagrees with this proposition. First, it is simply unnecessary to enlist the CPSO to regulate PAs. The CPSO already regulates physicians who are fully responsible for the practice of PAs. To add an additional layer of regulation over this required level of supervision

would be redundant, costly and confusing to both the public and stakeholders within the health-care system (i.e. health-care providers and administrators).

Second, RNAO is of the opinion that regulating PAs under CPSO undermines the principle of self-regulation of health professions. If and when PAs can demonstrate they are a stand-alone profession with the education, competencies and knowledge to offer the public unique access to health services, then they should be regulated under the *RHPA* and recognized as a stand-alone, autonomous, self-regulated profession with its own regulatory body. Until that time, the public will be adequately protected with PAs remaining unregulated and fully under the umbrella of physicians.

At this point, it is in fact questionable whether PAs constitute a stand-alone profession in Ontario. Not only are they wholly dependent on physicians for delegation, supervision and now proposed regulation, but there is evidence that physicians expect to be able to bill for the services provided by PAs under their supervision. In its Statement on Physicians Working with Physician Assistants, the Ontario Medical Association sets out principles to guide the relationship between the two provider groups: “Supervising physicians should not be adversely impacted financially. Physicians should be compensated for supervising PAs and, where necessary, reimbursed for administrative costs...The Ontario Health Insurance Plan (OHIP) fee schedule must allow supervising physicians to be compensated for all PA work that is carried out under delegation.”¹ Sharing the same CPSO regulator in the circumstances described here would contribute to a system of double dipping precious taxpayer dollars for medical services.

In the eyes of the general public, physicians who are reimbursed for administrative costs, receive a stipend (as is generally the case) for supervising PAs and, above all, bill for the work performed by PAs will be viewed as double-billing. If and when PAs become self-regulated, any supervisory stipend to physicians and any double-billing would need to stop, as two regulated professionals billing the public payer for the same health service would be utterly inappropriate from the standpoint of taxpayers and would ultimately compromise access to care.

For the above reasons, the RNAO recommends, in the strongest possible terms, that the CPSO not be involved in the short or long-term regulation of PAs. This would not prejudice the ability of PAs to become regulated under the *RHPA* at the appropriate time. Once PAs can meet the criteria of a self-regulated profession, including demonstrating with verifiable evidence the risks associated with the practice of a stand-alone profession *distinct from the practice of their supervising physicians*, then PAs will have the privileges and responsibilities of a self regulated profession accountable for their own practice. Stand-alone (not within CPSO) self-regulation, if and when all the criteria are met, is essential to protect 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*? (Please explain the rationale for your position. You may include evidence and/or citations where applicable).

No. While increasing access to care providers is currently an important goal for the Ministry of Health and Long-Term Care, we urge HPRAC to exercise due diligence and remain cautious of prematurely regulating a health-care provider that has not been able to provide the requested and appropriate evidence in their HPRAC application. For example, CAPA does not have access to and could not provide specific numbers or percentages of PAs who are Ontario-educated. As another example, complaints and disciplinary actions were not included in the application as evidence because these are not currently being measured by a formal process that provides any accessible information. This responsibility reflects on CAPA's inadequate engagement in quality improvement and quality assurance initiatives. Clearly PAs or those delegating to them, should implement some form of record keeping process to ensure quality and safety are safeguarded or improved without requiring PA regulation. The fact that all PA activities are delegated by physicians suggests that such record keeping should be an additional responsibility of the CPSO. It is not in the public interest to set up the machinery of self-regulation under the RHPA without clear evidence supporting that conclusion.

Furthermore, case studies provided by CAPA to substantiate their application are anecdotal in nature, gathered from interviews using self-report with individual PAs currently practicing in Ontario (p.6). This methodology is among the least rigorous methods used to collect evidence. While the study on "The impact of patient flow after the integration of nurse practitioners and physician assistants in 6 Ontario emergency departments" (Ducharme, J., Alder, R., Pelletier, C., Murray, D. & Tepper, J), provides much better evidence (using a retrospective review of health records data), results simply conclude the addition of a mid-level practitioner will improve patient flow in mid-sized community hospital EDs. Furthermore, this study shows that Nurse Practitioners (NPs) are much more effective than PAs in meeting each of the selected outcomes. Thus the evidence available actually contradicts CAPA's request for regulation since, according to this research, regulating PAs would not be in the public interest because the opportunity cost of funding PAs reduces the funds available to employ self-regulated, autonomous, more effective and less expensive professionals -- NPs. Further evidence on outcomes and evaluation in the Ontario context, is required to demonstrate convincingly that it is in the public interest that PAs be regulated under the RHPA at this time. Nor is it in the public interest to allocate further resources to demonstration projects. Such funding was not available to provide further evidence for other health-care groups who have requested regulation in the past.

It is astonishing that CAPA is requesting HPRAC to regulate PAs so soon, given that Ontario's first civilian physician assistant education program, a two year program, was only launched in September of 2008, with a class of 21 students. By way of comparison, it is important to remind ourselves that the regulation of NPs in Ontario took 30 years² and required extensive evidence including randomized controlled trials prior to regulation. It was worth the wait. Today, NPs are one of the fastest growing and successful health-care professions in Ontario and abroad.

Individual respondents to the HPRAC survey have suggested PA regulation is required because the field is growing in number. As HRPAC is well aware, growth in PA numbers was directly stimulated by the generous funding models of the Ministry, which were used to support the Ontario demonstration projects. Others have suggested regulation will provide PAs with a clear

scope of practice, a common set of qualifications and role clarity which will improve PAs' credibility and reduce the burdensome scrutiny of health professions who must remain mindful of PA's unregulated status. Fortunately, the purpose of regulation is not to define a health-care provider's role, nor to provide them with credibility, but to identify the risk of harm and regulate the profession in order to minimize the risk to the public. It is far better to establish the scope of practice as distinct from other groups of health professionals, build the credibility and develop the track record before, rather than after a decision on regulation that may be difficult to reverse. Therefore, the RNAO unreservedly urges HPRAC to recommend that adequate time and care be given to seek the necessary evidence before regulating PAs under the RHPA. Once again, 'parking' regulation with the CPSO in the short-term is not the answer and in fact can do more harm than good. Physicians are completely responsible for the practice of PAs. Adding an additional layer of regulation over this required level of supervision is not in the public's interest. Once PAs become an autonomous, stand-alone profession with established competencies, knowledge and education, then the RNAO will not hesitate in recommending regulation – independent from any other regulatory body (i.e. CPSO), under the RHPA.

3. From your perspective, has the applicant convincingly demonstrated that existing mechanisms (e.g., certification, supervision, etc.) are insufficient to address risk of harm arising from the practice of the Physician Assistant profession? You may comment on issues such as alternatives to regulation. (Please explain the rationale for your position. You may include evidence and/or citations where applicable.)

No. As mentioned in our response to question one, existing mechanisms (i.e. physician supervision, delegation procedures, medical directive procedures, communication requirements, assessment of competency, etc.) are sufficient to address the risk of harm arising from the physician-delegated practice of physician assistants. In addition, the Ontario Medical Association has safeguarded inter-professional collaboration, a contentious area that is weakly supported by evidence in the CAPA application, by stating “Delegation is carried out by direct orders or by medical directives. The development of medical directives, a critical component to facilitate the full functioning of PAs, should involve all members of the IPC (inter-professional care) team.” (p. 4)

Health care organizations, such as hospitals, long-term care homes, physicians' offices / Family Health Teams and Community Health Centres, also have mechanisms to address the risk of harm arising from the practice of a PA. Such mechanisms include: 1) promoting a culture of safety, which rewards near misses and organizational learning, 2) continuous quality improvement initiatives, 3) performance appraisals, and 4) bylaws that promote optimal inter-professional collaboration, to name just a few. The effectiveness of curriculum accreditation and PA certification remains to be seen, however each promote an additional mechanism for achieving a higher standard for conduct among PAs.

The RNAO is concerned that:

- PAs are at times given very complex responsibilities (i.e. prescribing and surgery) for the length of their education (two years),
- PAs may inappropriately order a high number of costly diagnostic tests to confirm their diagnosis, thereby straining precious health-care resources, and
- physicians are wanting even more distance from PAs and yet will seek to bill the Ministry for both their work and the work of the PA's services.

However, the RNAO respects the CPSO's ability to mitigate these risks effectively, without the regulation of PAs, and fulfill their mandate to protect the public from any negligence or professional misconduct by physicians.

Prior to seeking regulation, it is incumbent on PAs to first establish that they are a stand-alone, autonomous profession that offers access to high quality and safe care using the existing regulatory frameworks.

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. (Please explain the rationale for your position. You may include evidence and/or citations where applicable.)

No. Although CAPA's application (pg. 4) states "PAs possess a defined body of knowledge including clinical and procedural skills, and a professional philosophy to support effective patient care," and that PAs operate with common national competencies, CAPA repeatedly states the opposite throughout their application. These statements include: "To attempt a general description of services performed by PAs would be difficult," and "according to the CAPA position statement on PA regulation, the delegated practice of the PA must be consistent with the training and experience of the PA and qualifications and specialty of the supervising physician." Given this "scope of practice," only the PA's supervising physician will know exactly what is expected of the PA. If there are two physicians supervising the PA, or the PA wishes to change positions, it is unclear what the defined scope of practice will be for that PA. This will further confuse the inter-professional team (and patient) and create unclear expectations that may lead to unnecessary conflict.

RNAO is not questioning the fine and valuable service provided by Military PAs in the Canadian Forces, who have a long and proven history. By the time a soldier enters the Military PA program he or she will have had ten to fifteen years of clinical experience working as a medical assistant and will have served on several missions at home or overseas.³ In contrast, the civilian PAs who are being trained under the Ontario curriculum enter the workforce with inconsistent education (two-year bachelor of health sciences at McMaster, or four years at University of Toronto), limited clinical experience and are not subject to consistent standards of practice and supervision. RNAO is concerned both about the quality and length of civilian PA education. In contrast to the post-baccalaureate level education that NPs receive, and the baccalaureate or

graduate level education of Registered Nurses and Advanced Practice Nurses, there is no evidence that PAs who are educated at this limited and general level are adequately prepared to be autonomous self-regulated professionals.

Given the wide variance in educational preparation in Ontario (i.e. four to two year undergraduate studies), experience (medic experience in Armed Forces to no experience) and physician experience (general practice to surgical / specialist roles), we cannot conclude that PAs have a defined or common body of knowledge, as their application suggests. According to the CAPA position statement: "Requiring the scope of practice of each individual PA to be approved by the regulating college or medical board restricts the ability of supervising physicians and physician assistants to customize Physician / Physician Assistant Team practice" and that "the law should require that the supervising physician and PA jointly establish a written agreement outlining the PA's scope of practice that is approved by the physician(s)." To be very clear, expectations for the role and responsibilities of the PAs can only be confirmed on an individual basis. This is what RNAO would refer to as a "Scope of Employment" rather than "Scope of Practice." RNAO therefore recommends to HPRAC that PAs be known to have a "scope of employment" or contract of employment and, to avoid any further confusion with similar unregulated care providers (i.e. PSWs), CAPA should be encouraged to use this term until PAs have submitted convincing evidence to HPRAC that they have a defined and a unique body of knowledge to be self-regulated as autonomous practitioners. Anything less would promote a group of health providers that is not up-to-par with the other health professions regulated under the RHPA and could undermine the statutory regime under the RHPA.

CAPA's explanation of professional autonomy confuses the issue of accountability and is not helpful to the reader. According to CAPA's application, the continuum between autonomous practice and less autonomous practice seems to be contingent on the level of risk and the comfort of the physician in providing less supervision, as the case may be. The Ontario Hospital Association's (OHA) update on the Ontario Physician Assistant Initiative is perhaps more clear. It states: "At no time do PAs work as independent practitioners. All work performed by the PA is supervised by the physician who is responsible for all patient care. The supervising physician is required to ensure that the individual PA performs only those tasks that are within his/ her competencies and skill set and that can competently be performed on the physician's behalf" ⁴ (p. 1). This statement suggests PAs do not possess a unique body of knowledge and scope of practice, nor do they possess the high degree of autonomy that is required of those who seek regulation under the RHPA.

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. (Please explain the rationale for your position. You may include evidence and/or citations where applicable.)

Not yet. CAPA does not convincingly demonstrate that PA regulation under the RHPA is necessary at this time.

If and when the time is right, the number of PAs in Ontario will need to be re-assessed. Right now there are only 65 civilian-trained PAs and 65 Canadian Forces trained PAs practicing in Ontario. These numbers are expected to increase, given the additional 17 students who will complete their program and obtain employment through special funding provided by the Ministry. However, clearly these numbers are insufficient to provide the resources necessary for self-regulation. Moreover, we want to emphasize that it is unacceptable for the CPSO to offer itself as an interim regulator pending the ability of PAs to build the capacity to be self-regulating. It is self-regulation under the RHPA and providing the public with access to unique, high quality and safe care to which all health professions, including PAs, must aspire.

Aiming to become a self-regulating profession under the RHPA at the appropriate point in the future continues to be more practical than misplaced regulation under the CPSO. First, the economic forecast suggests this is not the time to sink scarce health care dollars into regulating a health-care provider's group that is currently, according to the evidence, doing well without regulation.

Second, Ontario is unique among the jurisdictions that employ PAs, in that Ontario has autonomous, safe, cost-effective and regulated NPs (1,500 out of 2,486 in Canada), who have been shown to provide better care than PAs at a lower cost.⁵ NPs require a minimum of three years in nursing education and two in NP-education, at the university level, and a minimum of two years clinical experience before becoming a NP. In contrast, the MacMaster Program for PAs requires a minimum of two years undergraduate education in any field (not necessarily health sciences), at any time in the past (even twenty years past), and no previous clinical experience. It is therefore not surprising that Ontario's NPs have been the beneficiaries of an ever-growing scope of practice reflecting their extensive education and competencies.

Third, physicians are currently paid an additional fee for supervising and delegating to PAs. As admitted by CAPA, the CPSO's intention is to allow physicians to bill the Ministry of Health and Long-Term Care for not only their own cost of service, but also for the service of the PA. It is essential that the overlapping compensation schemes that reward physicians for adopting PAs be recognized as wasteful and not in the public's best interest.

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. (Please explain the rationale for your position. You may include evidence and/or citations where applicable.)

No.

Impact on the expanding roles of other disciplines

RNAO shares with the Ontario Government a strong commitment to inter-professional collaboration with the objective of improving the public's access to safe, high-quality and universally accessible health services. Evidence shows repeatedly that this objective can be achieved effectively and efficiently by expanding the scope of practice of existing self-regulated health professions in accordance with their education and competencies. Examples of current practitioners who are increasing their scope and overlap with the PA were not provided by CAPA in their application. Among these are Registered Nurses, who could expand their scope of practice to include prescribing, and RN Surgical First Assists (RNSFAs), with additional certification in surgical assistance now having shown in a Ministry pilot project to reduce wait times, facilitate continuity of care and have a positive impact on patient outcomes.⁶ Clinical Nurse Specialists (CNSs) are Advanced Practice Nurses who have made a significant contribution since being introduced in the 1940s and are often working below their full scope of practice. New and emerging roles for nurses include mental health and addictions NP, continence nurse specialist, nurse hysteroscopist, forensic nurse examiner, critical care flight nurse and nurse psychotherapist. Midwives, pharmacists and other regulated health professions continue to expand their scope of practice, and RNAO has been fully supportive of their expansions as a way to advance timely access to quality care. Once barriers are lifted, and they should be, that limit the ability of currently regulated well-established health professionals to practise to their full scope, there most likely will not be the need to regulate another category of health provider.

For example, in order to increase access to health care professionals and promote optimal patient outcomes, RNAO recommends that the government move immediately with the following specific legislative and regulatory actions:

1. Amend the *Nursing Act, 1991* to authorize Registered Nurses (RNs) to prescribe medications appropriate to patient care; communicate a diagnosis; and set or cast simple bone fractures or joint dislocations.
2. Proclaim provisions of the *Regulated Health Professions Statute Law Amendment Act, 2009* (Bill 179) that would allow RNs and RPNs to dispense drugs.
3. Proclaim provisions of the *Regulated Health Professions Statute Law Amendment Act, 2009* (Bill 179) that would remove restrictions on the diagnostic tests that NPs can order; permit NPs to perform point of care laboratory tests; allow NPs to apply specified forms of energy such as defibrillation; expand the forms of energy that NPs can order, such as MRIs; permit NPs to order CT scans; and allow NPs, RNs and RPNs to perform psychotherapy as a controlled act.
4. Amend the *Healing Arts Radiation Protection Act, 1990* s. 6 (2) and (3), to authorize RNs with the appropriate education and knowledge to order simple x-rays of the chest, ribs, arm, wrist, hand, leg, ankle or foot, and mammograms.
5. Amend the *Highway Traffic Act, 1990*, s. 203 (1), adding the authority for nurse practitioners to conduct assessments of clients' fitness to drive.

In addition, government should invest resources in the development of effective funding models that support expanding proven and existing regulated health professions. The result would be much more cost effective, improve retention of highly educated health professionals and decrease the incidence of duplication and wait times for treatment.

Intra-professional vs inter-professional care

To avoid confusion and optimize inter-professional collaboration, physicians must remain intimately connected with the inter-professional care team, particularly in the planning and decision-making processes. They are also encouraged to facilitate the necessary communication that is required when orders are to be co-implemented by the nurse and PA. PAs currently work in an intra-professional role within the scope of medicine, not an inter-professional role, which was evident in the lack of evidence presented on inter-professional collaboration in CAPA's application. In fact, one can argue that the introduction of PAs to the Ontario health-care system has added another provider which fosters the fragmentation of patient care and promotes the discontinuity of patient care. Their unique contribution and role has yet to be documented to HPRAC and others.

Confusion with implementing physician orders

Using PAs has brought confusion into fulfilling physician orders, so much so that the College of Nurses of Ontario was prompted to address "Working with physician assistants" in their Frequently Asked Questions section online. This website states: "Nurses cannot accept an order or delegation to perform a controlled act from a health care provider who does not have access to controlled acts. If the procedure is not a controlled act, then whether a nurse may implement the order depends on the organizational policy and legislation that is relevant to the practice setting. As always, nurses should use their judgement and ensure their practice is consistent with College Standards" (CNO, February 17, 2012).

Cost-effective alternatives to PAs

HPRAC must be clear that the issue is whether civilian PAs, as defined in the Ontario demonstration project, provide access to high-quality, client-centred, cost-effective health care. Taking into account the limited education and experience of PAs in Ontario and their relatively high financial cost to the system, RNAO's position is that there are more cost-effective alternatives. In contrast to the unevaluated Ontario experiment with PAs, nurse practitioners have long-established the knowledge, skills, and competencies to provide access to essential health services in all settings at good value to taxpayers.

Currently, PAs represent an expensive cost burden to Ontario's health care system. They enter the workforce with earnings comparable, or much higher, than more educated and experienced nurses at the top of their pay scale. In 2009, Registered Nurses with up to five years of experience earned \$64,623 and those with 25 years of seniority or more were earning only \$78,000 a year. The salary for a graduate NP working in primary care ranged from \$74,038 to

\$89,203.⁷ While the salary range for PAs in the demonstration project reflected differing levels of experience, the base salaries ranged from \$75,000 to \$86,700 per annum.⁸ In addition, the \$72,000 stipend, which taxpayers pay supervising physicians over two years to “encourage participant” and to “compensate for potential lost earnings and productivity” must also be taken into account.⁹

While some may believe NPs and PAs equally contribute to quality, consistency and efficiency of care within the interprofessional team, the evidence to date is far less unequivocal. Studies by Ducharme, et al.¹⁰ and Ohman-Strickland, et al.¹¹ found differences in the quality of diabetes care in family medicine practices when influenced by NPs and PAs. Wilson, et al.,¹² also notes that quality of HIV care differed depending on whether it was provided by NPs, PAs, or physicians.

In summary, PAs must be held to produce the same rigour of evidence as all other regulated health care professions prior to regulation. It is not in the public interest to rush regulation by taking shortcuts or ad-hoc measures to inadequate regulation or failing to build robust evidence. Interim regulation through the CPSO is utterly inappropriate and is not in the public interest. PAs must demonstrate they have a unique body of knowledge and scope of practice, and can practice autonomously as a cost-effective, self-regulated profession. At that time, PAs may well deserve the support of the RNAO and other health professionals. However, given the current application and information available, RNAO strongly recommends against regulating PAs at this time. Regulating a health-care provider that has not clearly substantiated an application with sufficient evidence to become regulated, is not in the public’s best interest and contradicts the legislative framework provided by the RHPA.

In addition, RNAO recommends in the strongest possible terms, that if and when PAs meet all the requirements of a self-regulated profession, CPSO must not be the regulator. Embedding regulation of PAs in the CPSO will reduce transparency and accountability, contrary to the public interest, and will raise further doubts about the already questionable financial arrangements between the Ministry of Health and Long-Term Care, physicians and PAs.

Stand alone regulation, if and when all the criteria are met, is essential to protect the public.

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