University of Manitoba: "What's the Big Idea?"
Series 3, Episode 6: AARON JATTAN AND PETER NICKERSON

TITLE
Redefining Rural Healthcare: A Shift in Training and Care with Drs. Peter Nickers and Aaron Jattan

INTRO MUSIC FADES IN

INTRODUCTORY MONTAGE

1. https://www.youtube.com/watch?v=pycNidwM0ww

CBC News, Nursing shortage remains a major issue in Manitoba
"It's very unnerving that you worry that you're not providing the care the patient needs. It may be a new year but the nursing shortage and problems within the health care shortage in Manitoba remain."

2. https://www.cbc.ca/news/health/rural-er-docs-are-struggling-to-do-it-all-peer-support-programs-try-to-lessen-the-load-1.6735155

CBC News, Manitoba needs to do more to woo doctors to rural northern communities
"When we look at the four rural regions in Manitoba, the number of physicians per capita is below the average for similar regions in Canada. A shortage of physicians means patients can't always get the care that they need, when they need it and close to their home."

3. https://globalnews.ca/news/9233856/doctors-manitoba-optimistic-rural-health-care-changes/

Global News, Doctors Manitoba 'optimistic' about rural health care changes outlined in new report
"This morning Doctors Manitoba released a report outlining recommendations to improve health care in rural areas. The most urgent changes include expanding school programs to accommodate more medical students and recruitment initiatives."

INTRODUCTION

MICHAEL: Welcome to What's the Big Idea? I'm your host, Michael Benarroch, President of the University of Manitoba. In this episode, I speak with Doctors Peter Nickerson and Aaron Jattan about the very real challenges facing health care delivery, in this province and beyond.

Dr. Nickerson is Dean of the Rady Faculty of Health Sciences at UM. He's received numerous awards including Lifetime Achievement from the Canadian Society of Transplantation. Dr. Jattan is an associate program director in the Rady Faculty and serves as the Chief Medical Officer, here in Winnipeg.

In their roles, they work with stakeholders to address challenges in healthcare and ensure UM leads best practices in medical education.

We recorded our conversation, in front of a live audience, in Brandon, Manitoba, so you may notice a difference in audio quality from our usual studio recordings. But the big ideas are just as important. So, stay tuned, as we confront challenges in our healthcare system and ask, What's the big idea?

MAIN INTERVIEW

MICHAEL: Welcome, doctors.

AARON JATTAN: Thank you

MICHAEL: And thanks so much for joining us today. So, before we get into your big ideas, I wanted to set the stage and think about what is the state of healthcare in our province, right now? And what are some of the key challenges facing remote and rural communities? And are these unique to our province or are they indicative of what's happening across the country? And Aaron, I thought we'd start off with you.

AARON JATTAN: I think the concern on everybody's mind is what we're here to talk about, is the recruitment and retention of healthcare practitioners. And the question of whether this is a challenge that we're facing, across the province or across the country, we're seeing it everywhere. There's competition across our borders, within our borders, and we see the real struggle within our rural environments, absolutely. The tables that I sit at, with the chief medical officers of all the organizations that are responsible for healthcare delivery, we hear about the challenges that patients are facing, communities are facing, hospitals are facing. And this is a challenge, like I said, that doesn't just exist here in Manitoba, it's definitely across the country.

MICHAEL: Peter?

PETER NICKERSON: Yeah, so I would agree. I think the biggest challenge that we have is the lack of a workforce. And you keep hearing that all the time. And it's not just physicians, but it's nursing. And I have to be the dean of everything, in the five colleges that we have. We know it's in rehab sciences, so we don't have enough OTPTs and RTs, respiratory therapists. We don't have enough pharmacists. We don't have enough dentists, dental hygienists. So, all across the spectrum, we know that we do not have enough workforce to meet the needs and we've grown as a population. When we graduated med school back in the 80s here in Manitoba, we had a class size of 100. That shrank down into the 60s, in about the mid 1990s.

There was an idea in Canada that we were training too many physicians. And the entire country went to reducing the medical school sizes. So, we went all the way down to about 60, 65 medical students, at one point, in Manitoba. And we're reaping that effect now.

Did we respond to it? We did. We actually grew the class back in 2008. We got our class size up to 110, which was the largest we'd ever had in Manitoba. But then, our population kept growing. And we didn't grow the number of physicians being trained, to adjust for the population growth that we're seeing in the country, or in Manitoba. So, like when I trained, we were at 100 physicians trained per million population. In 2022, when I took over as dean, we were down to 73 physicians per million population, in Manitoba. So, we've created our own problem.

MICHAEL: So, we're now training more. You know, the provinces move forward. We're training across all the spectrums, but how long does it take to train a doctor?

PETER NICKERSON: Well, it takes four years to get an MD degree, but that doesn't give you a license to practice medicine. You have to do what's called a residency after that. If you're doing family medicine, that's two more years of additional on-the-job training. If you're going to do a specialization, like internal medicine, we're talking another five years.

MICHAEL: So, someone comes in today, because there's a shortage, so we train more. We're not getting new doctors for another six years, out of that bigger class. So, this problem is going to take a while to solve. So, let's talk about solutions. You have big ideas when it comes to healthcare in this province, Peter, and they overlap in some regards. So, let's begin with your big idea, which is the need to create and buy into a distributed education model. Can you tell us more about that?

PETER NICKERSON: Sure. So, we know there's not only a lack of physician workforce, but a maldistribution of physician workforce. There's just not enough physicians in practice. Well, how do you get people there? Well, the first thing you do is you have to make your training programs bigger, which we did. So, with the support of this government, we've expanded all of our programs to be training more physicians, but also to be training more residents.

So, we've expanded family medicine training spots by 30. We've gone from 52 family medicine spots a year up to 82. If I ask my family physicians, is that a toll on them, they'll say absolutely and especially because we can't do that all in Winnipeg. By this year, our class size is up to 140, as we start bringing those 140 into residency. If we haven't created a network for training our students, across the province, we won't be able to have enough spots to train them. So, we absolutely need cities like Brandon to be a major training centre for our students, as well as many other sites across Manitoba. So, we're in Steinbach, Beausejour, we're in Dauphin. We've been in Dauphin for many years and we're now open in Neepawa. Neepawa for the first time is taking family medicine residents on board and they're terribly excited about that. We're up in the Pas, we're in Thompson. So, all over Manitoba, we need to utilize all the opportunities we have, to train students. And what we believe, is that if you go to a community and you train, I think the chances that you're going to stay there are much higher than if you've only trained in Winnipeg and then we're asking you to go someplace you've never been to before. So really, we need to engage the communities, as part of the solution, which is to create a training platform right across the province, and Brandon as a city centre is perfect for this.

MICHAEL: Thanks, and Aaron, your big idea is something you've long advocated for. You suggest that Canada should create a rural doctor designation. Can you tell us more about that?

AARON JATTAN: When I was working rurally in Steinbach a few years ago, myself and Dr. Charles Penner, who's the chief medical officer in the Interlake, we wrote a paper advocating for this idea of a specialty of rural generalism. And just for context for everybody, so, the College of Family Physicians of Canada certifies all family doctors in the province across the country. When you complete an accredited residency training program, you complete the examination and you're given this designation, the CCFP. And one of the features of this CCFP designation is it's touted as portable. You can work anywhere. You train in Toronto, you train in Vancouver, you train in Montreal, you can work in the Pas, you can work at Red Sucker Lake, you can work in Red Deer, you can work anywhere. It's something they tout with that designation. I think, the idea is nice in theory, and in practice, I don't think it lends itself to be quite true. I think it also devalues some of the work that I see, the docs who I trained with, my rural colleagues.

These are some of the most immensely skilled clinicians in the country. And sure, urban family medicine, rural family medicine, there's a spectrum there, absolutely. But other jurisdictions have looked at this. So, Australia, Queensland as the example, they have rural generalism as a recognized specialty, with its own formal training track. And I think the foundation by which we build our rural recruitment and retention strategies, we approach it almost from a deficit mindset. We say, we're gonna pay you more because you have to work in a rural environment.

We pay you more because you have to live rurally. We pay you more because we're assuming, in some cases, that you want to live in an urban place but you're working rurally. Whereas I think, you know, there's a lot of benefits to living, working, rurally. And I would rather approach it from the mindset that, you know, we might pay you more as a rural family physician comparatively to an urban family physician because you are recognized as a skilled clinician, with an incredible breadth of scope and practice.

And let's not talk about money because it's not just about money. So, when I'm meeting with residents as they're about to graduate and I say, you know, what are you interested in, when you go out into practice? And they tell me, I'm interested in teaching. I'm interested in being part of the university. This is no disrespect to the University of Manitoba. We see this across the province-or across the country, there's a significant under-representation of rural generalism in academia.

And so, the legacy of a centralized medical system is we've created this message that if you want to be involved in academia, you have to be in an urban centre. And one of our goals, you're talking about the University of Manitoba being Manitoba's university, is I want a resident who is graduating from Thompson or from Brandon, from Dauphin, to come out with the idea that if I want to be involved in academia, if I want to be involved in research, I want to be involved in teaching, I can do that anywhere. It doesn’t have to be just in Winnipeg. And part of the idea of having a rural generalism as a recognized specialty is it would really drive that recognition that this is a unique opportunity, a really exciting opportunity, to be part of something. Right now, in some ways, it feels like an adjunct to urban family medicine when we do the training within the city.

MICHAEL: And I love that because it would commit the training institution to have this as one of their priorities, right? And again, not because there's a shortage, but because that's the right thing to do. So, I love that approach you've taken, and you've written about that. You did your family residency here, in Brandon, and you told me you fell in love with the community.

AARON JATTAN: Absolutely

MICHAEL: Can you tell us the story and what happened in your final days as a resident here?

AARON JATTAN: So, don't hold this against me, I'm from Toronto.

AUDIENCE LAUGHTER

AARON JATTAN: Born and raised in the GTA. I met my wife in medical school, in Ottawa. Who's a proud Manitoban. She decided, near the end of our training in Ottawa, that she wanted to move back home.

Initially, she dragged me kicking and screaming. But I'm here with two kids now. We have a house. We're going to be here for the long haul.

MICHAEL: I'm liking you more now.

AUDIENCE LAUGHTER

AARON JATTAN: But through my exposures in medical school, I fell in love with rural family medicine. I was amazed by the breadth of scope, the skill that these clinicians had. Personally, professionally, I wanted that. And I was fortunate enough to match to the Brandon training program here. And let me tell you, like, a bit of a culture shock for somebody who's never lived in a city with less than a million people, moving to Brandon. But within three months, I had fallen in love with this community. And I had recognized, very early on in my training, that I wanted to maintain a footprint, here in Brandon.

And I met with leadership at the time, in Brandon, near the end of my training. And it was a very brief conversation, but the message was, we're full. Best of luck to you. And it was kind of a jarring message to be told, at the time. I kind of didn't really know how to feel. It felt like I wasn't wanted, honestly. And I had to pivot.

MICHAEL: I mean, this is a story I've heard before, from residents and young doctors. Do you think this is in part, because whoever is offering the positions looks at the makeup of doctors today and says, well, we can't afford another one. Doesn't kind of look forward three years and say, oh but we're gonna need this person in three years. And in fact, in how competitive it is to recruit doctors, it might be a strategy, a little bit forward thinking, about how we recruit doctors to communities.

AARON JATTAN: I think as stakeholders, and I can't speak to the way we recruited and retained at that time, but at the tables that Peter and I are sitting at, I think there's a real push to be nimble and flexible. So, “we're full” is not an answer, right? It's how can we look at the needs that we have within our cities, within the province, and meet with that physician and figure out a sustainable long-term fit. And I think we're seeing that, at the tables that we sit at now, that all stakeholders are pulling in the same direction. We're all willing to be flexible in the way that we tackle this problem.

MICHAEL: So, Peter, talk a little bit about that, stakeholders working together, and the different rules at stake. There's government, there's the university. How does that all work?

PETER NICKERSON: Sure. I mean, there’s multiple players here. There's the government that is going to fund both the health system, as well as the educational system, different ministries but still from the same government. There's the health system, but here we have now regional health authorities that are all over the province. We have a central health authority, Shared Health, which is trying to coordinate some of the logistical types of support, and I would say we're emerging out of the pandemic, starting to recognize the urgency of coordinating together, working more together, certainly workforce planning together.

One of the big things that I think Aaron and I have been challenged with, with the other health authority chief medical officers is where's the workforce plan for the province? How many family physicians do we need? How many obstetricians do we need? How many pediatricians do we need? That and where do we need them? That kind of planning. And I see Dr. John, in the front here, who's CMO for Prairie

Mountain, saying the same thing. Yeah, we don't have that sort of overview workforce plan, but that's something that we're absolutely being demanded to come up with now. And this government's actually holding our feet to the fire saying that we really need to have this workforce plan, so that we can properly plan forward, and as you were just talking about the flexibility of that plan, to project out, you know, it used to be until somebody retires, you're not allowed to hire into that position. Well, if you're telling the person there's no position for six months because we're waiting on a retirement, they're not about to say I'm taking no income for six months. They're going to go find a job. And get them back afterwards? It's not going to happen. So, that kind of flexibility within the government, within the health authorities, has to come into play if we're ever going to break this forward to actually meet the needs, in a way that we, you know, we take a little bit more cost here at this time point, but it pays out over a 30-year career, right? We're not talking about a one- or two-year investment. We're talking about somebody working in a community for 30 years, if you can get them to sign on.

MICHAEL: Aaron, any thoughts?

AARON JATTAN: Regionalization of healthcare is such an interesting thing, in that sense, because if, as many people know, we regionalized healthcare across the country, most provinces in the 90s. And one of the hopes was that the regions would all kind of coordinate and work together. I think we're seeing that now, but regions, if you look at the letter of the job descriptions for the individuals, for the chief medical officer, for Prairie Mountain Health. I'm the acting chief medical officer in the Winnipeg Regional Health Authority. By the letter of our job mandate, we are responsible to our health authority, right? So, for recruiting a physician, if I'm recruiting a physician within Winnipeg, and I'm paying for that physician, with my budget, I by the letter of my job, I'm making sure that that physician is supporting as many patients in Winnipeg, and Winnipeg operations as possible. But fortunately, I think the people that are sitting at the table are viewing this challenge through a different lens. We are viewing it through the lens of what is good for a patient in Brandon, in Neepawa, in the Pas, in Thompson, is ultimately good for a patient in Winnipeg and vice versa, right? So, I'm thinking about, if I'm recruiting a physician, how can that physician also support people in Brandon?

Dr. Fung will forward me resumes for physicians that are looking in Winnipeg. So, I think the university sits at this table as a really important stakeholder as well, because often when we're recruiting, there are specialists that want opportunities in research and administration and leadership. So, offering those opportunities, the university has to sit at those tables, they're a critical part in helping us recruit physicians into the province. And I think this government's been quite nimble with us, in allowing us to explore opportunities that, even if it might not be a critical need as Peter was saying, over 30 years, we might eat some costs up front but we're gonna win that back, at some point.

MICHAEL: What's interesting about what you're saying, a little bit shocking that it hasn't been done that way, because it sounds so logical when you say it. But a good crisis often makes us relook at the way we're working and think about where all the failures have been and, you know, where the strengths are and to build on that. And so, I think you've brought up a really good example of how changing the way we organize the hiring process, all the health authorities working together, because it is one system. It was probably envisioned that this would naturally happen, but you just gave the exact reason why it didn't. Your responsibility is to Winnipeg, right? And all the other health authorities, in the same way. So,

as we're doing this then, and you talked about the university, we have a responsibility for the whole province. We've always had that responsibility. So, Peter, I'm going to ask you about, the steps required to create a medical satellite campus in Brandon. But before you answer those steps, tell me why Brandon.

PETER NICKERSON: Why not, Brandon? I think you have a city here that, if I look and compare it to other places in Manitoba, you have all the key elements of what we need for training a med student from Med 1 through to Med 4, which is, you have all the specialities. You have emergency medicine, you have family medicine, you have internal medicine, you have surgery, you have pediatrics, you have ob-gyn, you have psychiatry. These are the big disciplines that we have to train all our students in.

You have it all here. And there's not many places that can say you have it all. We absolutely need to be here and leveraging all the resources and investments that have been made in the health system here. Because we cannot, as I said earlier, train 140 students that we currently have. And certainly, if we can create a satellite campus here, in its full construct, we can even expand further and actually have the overall number of medical students being trained, up to about 150, of which we would bring 16 here to start, and have 134, in Winnipeg. That would get us to 150 total, and if you actually go back to the math, we're gonna be at 1.5 million, in a couple of years. That means we're training 100 per million, which is what we were doing in the 80s, we're getting back to where we started, right, at a rate of training. And we didn't have doctor shortages in the 80s, when we were training 100 per million, right? This would allow us to get back to that capacity, but we can't do it all in Winnipeg. We need to be here.

MICHAEL: Brandon's the second largest city in the province, but it's really that breadth of practice that is happening here that makes Brandon ideal. So then, what are the steps required to create this satellite campus?

PETER NICKERSON: Well, to actually train medical students, you need physicians. So, it really starts at the end, which is, do you have enough physicians to be educators in a medical school? And that is when we looked at the problem overall. And I just told you, we undertrained physicians for so many years, and we have a workforce problem in the province.

And that's why we put a lot of emphasis on expanding our residency training program and, in particular, residency training in Brandon. Because after a couple of years, we would have more residents trained here. We would hopefully retain them here. And then you have the pool of medical educators. You already have a satellite here of our campus. It's been operational for many years. What we want to do is scale it up. Right now, 8 or 9 are here, in total. Ideally, we'd like to get 32 and we think we can do that. What we need to do that, is we need the hospital. So, we have our CEO of Prairie Mountain here, Trina, where you have a brand-new wing being built on the Brandon Hospital, that will build training capacity for us. It's a place where our Med 3 and 4 students can be trained, so we can actually expand up the third and fourth year. Once we have that expansion underway, then we need to think about how do we get Med 1 and 2 here. We need a building to do that.

We need actual physical space, outside the hospital, where we can train our students in Med 1 through 2, but again we need physicians to be the educators in that program. One of the things that we did differently in Winnipeg, this year, was we actually brought family physicians in to teach our Med 1 and

Med 2 students. One of our biggest gaps we have, in medicine, is not enough primary care physicians. In the medical school, we were only modeling family physicians at Med 3. You did a rotation in a family practice, for six weeks, and that would be your exposure to a family physician. Well, that's not really giving the signal that we value family physicians, right? All the rest of your time you've been seeing specialists. So, what we did this year, in Med 1 and Med 2, was we had all of our medical students work in small groups, groups of 8, and their mentors in those groups teaching them were family physicians. So now Med 1 and Med 2 is fully mentored by family physicians. Well, that's a great way to have role models and to have people aspire to be family physicians.

MICHAEL: So, the plan's in place, very well. In fact, it's started already. And we have boots on the ground here, in Brandon, working on it. And hopefully, this will lead to the expansion that we're thinking about. So, we build this education hub, here in Brandon. What comes next, in helping cities like Brandon and then rural communities, to recruit and retain the physicians, Aaron?

AARON JATTAN: I think we've been chatting about we want learners to do the bulk of their training, as much of their training as they can, in that environment, right? So, we already have a distributed medical education model to some degree, within Manitoba. We have four urban training sites within Winnipeg, and we have 10 rural training sites across the province, right? So, what we're talking about here is expanding that medical school piece, but we have residency site operations from Steinbach to Boundary Trails to Neepawa to Dauphin, Thompson, North fly-in communities. So, we do already have the makings of a distributed medical education model.

The next step of this is how do we keep our learners, our residents specifically, engaged in those communities for as much of their residency as possible. So, Brandon is the perfect example because it's one of the reasons I've selected Brandon as a residency program, I wanted to be here, is you could do most of your training in Brandon. So, if you're training in Steinbach, you will go into Winnipeg to do your obstetrics and gynecology, you will go into Winnipeg to do your internal medicine, you'll do a blend of emergency medicine within Steinbach and within Winnipeg. And many of our rural training sites operate that way. And in some cases, you've really diluted that exposure to that community. So, our challenge is how do we leverage communities like Brandon, with the capacity that it might allow, to get more training done, either at your home site or as close to your home site as possible, and in a completely different mindset, not just within the distributed hubs that we're talking about here. I think we just need to be more intentional as a training program, in general, about letting our graduates know "there is a job here for you." There is an opportunity here for you.

It sounds intuitive, it sounds straightforward, and I don't mean this with any ill intent, but that message was not there when I was graduating, right? I think we're working very hard now, when we meet with residents, we try to meet with them from day one of their training, and we meet with them periodically throughout, right into the end, to say, "there are jobs here for you in Manitoba, let us know what you wanna do, we will work with you, we will put you in touch with the right people, we will find you an opportunity here."

So, it is trying to make sure those individuals are immersed in the community for as long as their training as possible. They feel connected to the broader community and that they are aware of those opportunities that are available for them, the moment they graduate.

PETER NICKERSON: Absolutely, I think you need to be thinking of Brandon as a hub center, where you have all these spokes out to the communities that you just mentioned like Neepawa, Dauphin. You could think about other communities around here. But Brandon could be a hub, where it's a centre of education, it's a centre where it could be leading a lot of the type of research you're talking about in rural medicine, right? Even though you're in a city here, but you're serving so many rural communities around, right? So, you could be leading, in the education in that, and the research and the knowledge gathering, in that area. So, I think that's a huge opportunity that's afforded by creating a real hub in Western Manitoba.

AARON JATTAN: And you think with its success, how that could translate into other areas**.** You look down the line, you see Selkirk as a hub, Steinbeck as a hub for smaller communities that branch out around there. The model has tremendous potential.

MICHAEL: Well, and we've been at this for a long time. I mean, it wasn't we woke up yesterday and said, oh we need more doctors in rural places in Canada, right? This has been going on for a long time. And so, changing the way we approach this obviously is part of what we need. We obviously need to do it in an intelligent way. But it's obviously part of it. And so, I think this shows great potential. Now, just switching gears a little bit. We've been talking a lot about physicians but if we want to really address the gaps in healthcare, we can't rely on doctors alone. So, how do you both view changing the scope of practice to enable other healthcare practitioners, pharmacists, nurses, physician assistants, to do more, to contribute more, and how might we restructure medical care, to be able to do that?

PETER NICKERSON: I think there's a couple of things that we're trying to do at the U of M and the Rady Faculty of Health. We're trying to send a lot of our learners out to communities. So, our pharmacists go out. Our occupational therapists, physiotherapists, we send them out, beyond the perimeter, to get training in all kinds of centres. A number come here to Brandon, a large number. And what we're trying to do is start sending them as teams. The idea that you're actually sending out groups of students who are of different professions, but they're learning to be interprofessionally educated together, and that we start creating environments where you can have team-based care. One of the things that happened in British Columbia was a lot of family physicians just closed down their practices.

Why? In the old model, they would think that, oh some young person who's graduated is going to buy my practice and now they're going to take over my practice. This generation is not interested necessarily in running a business. They're interested in giving healthcare. That's what they've been trained to do. They've been trained to be physicians and to deliver care. So, I think we need to start thinking about what's that model of care that we could actually bring physicians, pharmacists, nurse practitioner, midwifery together in a group practice, where they're actually serving a huge population, more than a single physician can do on their own, and they're bringing their interprofessional skills to patient care where the patient' s at the center and you have this team-based care. And I think that actually could have a real impact and make our health care workforce have a broader impact, instead of saying I all I need is this or all I need is that. So, I think this idea of team-based care is something that's coming. The idea that physicians are going to be private practice businessmen, that is, or women, that is going out the door. So, I think we're going to have to look at scopes of practice as a small part of that whole envisionment of what is team-based care going forward.

MICHAEL: Aaron, any thoughts?

AARON JATTAN: Our family medicine residents, across the province, primarily train in team-based care settings. So, whether it's in Winnipeg, in Brandon, most of the clinics that our residents currently train in have physicians, have nurses, have physio, occupational therapy, pharmacists, social work. So, to expect an individual who is trained in a team-based care environment to go out to practice and operate as a solo practitioner, is probably not a recipe for success, at the end of the day. I think enough literature has shown that team-based care is not what's just best for the patient because we have our collective expertise and our collective scope of practice that can meet the patient's needs holistically, but it's good for the physician, as well, from a burnout lens. We want to do good work, but when we're working as a team, the job becomes a lot easier. One of the best parts of my job at St. Boniface Hospital, where I work, is that I get to work with a team. I get to work with the physiotherapist. I get to work with an occupational therapist. I get to learn from them on a daily basis. And it's not just me there. We're working together, as a team. We're all pulling in the same direction. Our residents are training in that environment. And so, this is a big piece of the puzzle, as well.

MICHAEL: But you think about our system in public healthcare in Canada, a publicly funded system. Canada's system's been criticized as leading to poorer services and delivery of health outcomes compared to, say, other systems like the U.S. where you have a private system. You always hear the stories. You can just go to a doctor, and you can get in right away and you don't have to face all the lineups. But is this true?

Does the U.S. system, for example, is it avoiding these complex issues that we're seeing here, in Canada? Do they have shortages of doctors? Are they suffering from the same things?

PETER NICKERSON: So, I think the real question, you're seeing the debate now going on in the U.S., is can I afford health care in the U.S., as a private citizen? If you're with a company, then maybe you can afford your healthcare because your company is going to look after that. But apart from that, the cost of insurance is unbelievable. I think the thing I've seen in the news lately is talking about how you can go bankrupt if you get sick, right? You can't afford to get sick.

I'll make it a little bit more personal. I was living in the States and had an HMO, was my health care provider. And my daughter, on the day before we were supposed to drive home to Canada, ran down the hall, broke her wrist. And I was required to phone the HMO. It was obvious she had a broken wrist. I had to phone the HMO before. Supposedly I was allowed to take her to the emerge. Well, I just took her to the emerge without phoning the HMO. And of course, they fixed her, her broken wrist. But then I had the HMO trying to recover the cost of the emergency visit, from me personally, for the next five years. Like, it was crazy like, what are you talking about? Of course I'm gonna take her to the emerge. She has a broken wrist. So, there's that kind of bureaucracy in the U.S. health system that people don't talk about, but it's there.

AARON JATTAN: You mention if they're facing the same challenges, I think it's where you look, right? At the end of the day, I had this very interesting dynamic where I have an uncle in Pennsylvania, who's a general surgeon, working at one of the top hospitals there, and his wife is a family doctor, who works under the Medicaid lens, dealing with low socioeconomic individuals. And I got to go and shadow with

them, when I was, before I went into medical school. And the hospital was beautiful. I've never seen a hospital like that in my life.

And when I went with my aunt, who's a family doctor, they had no staff. They were challenged to meet the care needs of the patients that they were serving, that really needed care. So, I think if you look hard enough, you'll see some of the same challenges that we face here. But I had no interest in working in that system.

MICHAEL: A much more unequally distributed system of healthcare. I think what most Canadians like about our system is that more equitable distribution. And even within there, there's issues. So, I want to thank you both for that. And we're going to continue to answer questions.

So, we've got a mic or two going around. So, if you have a question, please put up your hand. We'd love to hear your questions.

AUDIENCE MEMBER: I'm Bill Holden, the Mayor of the Town of Melita. One thing I'm not hearing about is nurse practitioners. Nurse practitioners, where do they fit into the system here now? We have two in Montague, right now, in the hospital and one more will be graduating here shortly.

PETER NICKERSON: So, we have a training program for nurse practitioners in Winnipeg. We've had 25 per year. It's been our intake that the government has funded. They've just now expanded that to 50. But what we've realized is that nobody really wants to leave their job to come to Winnipeg to do the NP program.

And so, what we're going to be doing with our nurse practitioner program is we're going to offer the opportunity for 25 of the 50 to train, in person, in Winnipeg. And the other 25 is going to be a virtual curriculum, so they can train where they live to become nurse practitioners. So, if you have an individual who's a nurse now, who wants to do that extra training to be an NP, they can do it where they live and work and have their family. There will be a requirement for, I think it's like, a week, two times a year, to come into Winnipeg to complete the course, but essentially, they do most of the training on site where they're living. And we think that's gonna actually address a big need, especially for rural northern communities, where we know there's a lot of nurses that have the capacity to do that training and want to do that training, but they haven't been able to say, "I'm gonna uproot myself for the time that it takes to train and go to Winnipeg to do it." So, we think this is going to actually open up NP training in Manitoba and start addressing some of the needs that are outside of the Winnipeg area.

AUDIENCE MEMBER: Thank you so much. My name is Michael, and I live here in Brandon. So, my wife is an internationally trained pharmacist and when she arrived here in Manitoba, she had to go through the credential assessment process which, involves writing a couple of exams. The University of Manitoba offers group classes for the evaluation exams and so it is easy, as far as the evaluation exams, but that support ends there. Once you leave them alone, it's difficult navigating the other processes and so I've seen that she has been struggling. So, my question is, how can the support system be improved, to better assist internationally trained, for example, pharmacists when they arrive here, in Manitoba?

PETER NICKERSON: Yeah, it's a great question. I haven't really been involved with the College of Pharmacy to know where they're at with supporting internationally trained pharmacists. So, something I'm going to go back home and find out more answers, and I'll get back to you, Michael.

We have also looked at internationally trained physicians, and I'll maybe draw the analogy of what we've done there. Manitoba has been very innovative. We're the only place in Canada where, if you're an internationally trained physician, but you haven't met the licensing requirements of the college, we offer a one-year training program for those individuals to be assessed through that training. And at the end of that training program, they can then get their license, and then they have, I think it's five years to write their family physician licensing board exam. So, we've been getting 30 family physicians trained through that program now, per year. We used to be 20. We've ramped up to 30. And so, we're having individuals, who are now located in Manitoba, been internationally trained, but haven't been able to get a license, now able to get a license and practice in Manitoba. The rest of the country has looked at us and said that's a model. They wish they had that program and we've been doing that now, for 20 years. So, the analogy I would draw is maybe that's what we need to be thinking about with internationally trained pharmacists. So, when I get back, I'll talk to my Dean at the College of Pharmacy and see where they're at.

AUDIENCE MEMBER: My name is Michelle Desla. I'm rural family doctor. I work in Neepawa, I was very glad to hear Dr. Jattan talk about a designation for rural family doctors because I don't know that I could work in a city. I don't think I would remember how to do it. Rural medicine is really, really different and my question and comment is about a third of our province is outside of the perimeter. And we know that rural patients tend to have a lower or fixed income, are more likely to be elderly or retired, and we have a higher proportion of Indigenous people in rural areas. So, when we're talking about a healthcare workforce plan and planning ahead, how do we take an equity lens to where we are placing, you know, the resources? Thank you.

APPLAUSE

PETER NICKERSON: One of the things we're looking at now is how we admit students to our programs. And we have a very diverse student body. In that sense, I have no concerns. Where I have concerns is, are we representing our rural communities well, in the intake into the program? I don't think we've got a really good handle on that. We believe about 25% of our students, when we do our learner survey, indicate that they're from a rural background. But again, I don't really have a good handle on what that means, as how that's being currently asked. So, we're trying to reformat that question better.

We absolutely are looking for more Indigenous learners coming into our program. 20% of our population is Indigenous. We need to be training Indigenous physicians, Indigenous nurses, Indigenous OT, PT, Indigenous pharmacists, like right across the spectrum. And where we've been successful in that, in the medical school class, we've been seeing our Indigenous physicians going to northern communities and serving communities that they're from.

So, there's a real commitment from the Indigenous community, to serve the Indigenous community as physicians. And I think we need to have the same lens in our admissions criteria, looking at are we having enough students coming from rural communities who want to serve in rural communities? And so

that's another piece of what we're doing is we've committed to re-looking at how we do our admissions criteria for medical school. And we're bringing forward a proposal, this year, that we'll be looking at trying to ensure equity in multiple dimensions, so that we're actually serving the communities that we represent, here in Manitoba. So, that's my best answer to you for equity.

AUDIENCE MEMBER: Thank you. I'm Beverly Hicks. I've been a psychiatric nurse and psychiatric nursing educator for about 40 years or more. I'm really pleased to hear that you're talking about a team approach and training all kinds of other health professionals and not just looking at the physician. But the other side of the equation, we're talking about a supply-demand system. What we maybe need is less patients. Now, what I mean by that is that there are so many other health professionals that people can go to and yet in some people's minds the physician is the point of contact. But if we look at, you know, maybe a nurse practitioner, maybe some other kind of practitioner as the point of contact, almost in a triage kind of system, where the physician is just one of many others.

PETER NICKERSON: Yeah, so we totally agree with you and one of the reasons we do need to look at scope of practice, beyond what we currently are allowing, but that's a regulatory issue that's dealt between the various regulatory colleges, in the province. So, we're advocating for them to relook at what they're doing. The other, you know, the team-based care model that we're talking about. Certainly, physician assistants are also in that model. And in some of the team-based care centers that Aaron's running in Winnipeg, you may not see a physician. In fact, you actually see your PA or you see an NP, and you don't see the physician, right? So, it's really, I think we're talking the same thing. It's just a matter of bringing that model and making sure it expands throughout the province.

AARON JATTAN: You're a patient of a clinic, right? Or you go to that clinic, that home, that's your care home. You might see the physician because you need to see the physician, but your needs can be met by the nurse practitioner. You might need to see the physiotherapist. Like that's the model that we're striving for. I think that's the sustainable long-term model that's best for patients, and best for all the providers as well.

MICHAEL: Here's the good news, that's what we're teaching our students. The system hasn't caught up yet, fully. It's starting to, but I think there's a recognition in the system that that needs to change. But the first step of that is training.

AARON JATTAN: And we're teaching this too. It's beyond the clinic too. Like, it's the community. I'm speaking because I'm a family doctor. Family doctor, family physician, family medicine is rooted in the community. So, the community is part of the care team, as well, in many ways. You need to understand what the resources are within your community. Just as an example, what are the gyms in your community? Like who are there that can help support me with weight loss or nutrition, things like that, as well. So, it's beyond the clinic as well. It's understanding what's available in the community. We're all trying to do this together.

MICHAEL: So, we are out of time. And I want to thank everybody. I know we could keep going on with this. We obviously hit the right topic, at the right time. I want to thank our guests, for a really fascinating conversation.

AUDIENCE APPLAUSE

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MICHAEL: I hope you enjoyed this episode of What's the Big Idea? To learn more about the Rady Faculty of Health Sciences, visit umanitoba.ca/health-sciences. Or find the link in the show notes. Until then, keep thinking big.