Ontario Medical Association, District 2
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Dr. Steven Bodley
The College and Physicians and Surgeons of Ontario
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Toronto, Ontario
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continuity@cpso.on.ca

Dear Dr. Bodley:

Re: Proposed *Continuity of Care* Policy

This letter is written on behalf of the physicians in OMA District 2 to express deep concerns regarding the CPSO's proposed suite of policies titled *Continuity of Care*. Given the current state of healthcare in Ontario, worsening burnout rates for Ontario doctors, and growing system-wide pressures, an extensive and binding policy such as *Continuity of Care* places undue distress on the already overburdened physician workforce. It is highly likely the policy will have unintended consequences that further erode access to healthcare for the neediest Ontario patients. It is predictable that doctors will react by leaving Ontario or opting out of primary care. This will magnify the strain on those physicians working themselves hardest for their patients, both rostered and orphaned.

We appreciate the CPSO's long, thoughtful effort in drafting these policies. Moreover, we applaud the recent cordial meeting between the CPSO and OMA senior staff, and the extension of the consultation deadline. Close cooperation between Ontario's doctors and the CPSO is of the utmost importance in developing the best policies for patients and physicians alike, within the constraints of the current care and funding models. However, the unfortunate truth is that many physicians are worried that the CPSO will push ahead with these complex policies notwithstanding our sincere concerns. We are hopeful the CPSO will work with doctors to build the best possible health care system for all Ontarians.

Patient care and patient safety are the top concerns for all Ontario physicians. While the College's focus on enhancing care is appreciated, Ontario's doctors feel that complex care policies such as *Continuity of Care* would be best addressed in direct cooperation and negotiation with physicians, rather than through further regulation. It is our opinion that provision of after-hours coverage falls under the umbrella of negotiations between the OMA and the government of Ontario. Given disparities in the geographic distribution of doctors across this very large province, some aspects of *Continuity of Care* might very

well prove infeasible. Ontario's physicians already provide after-hours coverage to the best of their abilities. *Continuity of Care* increases the after-hours demands on physician services without due consideration of the human resource implications, particularly in areas where doctors are in short supply. For example, there might be community-based specialists such as neurologists, psychiatrists, or internists that do not belong to the local hospital group or are the only practitioners of that specialty in a particular area. Providing the after-hours coverage or shared on-call service as outlined in *Continuity of Care* may not be possible without an onerous impact on doctors' personal physical, mental and emotional health.

Community-based specialists may leave the outpatient world and restrict themselves to hospital practice. Or they might leave rural Ontario for cities with much larger call groups, thereby worsening access to specialist care in smaller communities.

Consider Psychiatry as an example, a specialty where patients routinely await upwards of a year for non-emergent consultations. There is a vast shortage of psychiatrists that provide ongoing psychiatric care in the community. *Continuity of Care* might push psychiatrists to urban centres, or hospital-based jobs in consultation-liaison. The mental health crisis can only worsen in such circumstances, leaving vulnerable patients and their families in the lurch.

The seemingly innocuous emphasis on the availability of an answering machine for patient messages also opens the door to adverse outcomes for the patient. If a patient leaves a voicemail after hours that is not retrieved overnight or on the weekend, is there not a risk to his or her safety? The patient might delay seeking urgent attention, waiting on a phone call that might not come for days. Or what if the patient's message is incomplete or unintelligible, or includes no callback number? Is the unreturned call not false reassurance to the patient that there are no urgent concerns on the doctor's part? It's also hard to overlook the current fiscal climate, with steady increases in overhead costs against ongoing cuts to remuneration. The human resources demanded by the voicemail services demanded by *Continuity of Care* further threaten the economics of office practice. Doctors will be motivated to change or limit their scope of practice, close their private offices, or leave Ontario altogether. Again, this will only exacerbate the ***impending*** crisis of access to primary care.

We also ask the CPSO to reconsider some aspects of the proposed policy that govern Walk-In Clinics. The College writes, "Physicians practicing in a walk-in clinic must provide the patient's primary care provider, if there is one, with a record of the encounter" (goo.gl/RPVQDS, lines 93-94). It may not be logistically possible for high-volume walk-in clinics to forward records of every patient encounter to the patient's primary care physician. We agree with an expectation that a walk-in clinic should report high-acuity encounters to a patient's primary care provider. In the absence of a province-wide EMR, however, a requirement to fax a record of every walk-in visit is excessive, and of little clinical value. As currently drafted, the policy demands notification for every suture removal, every viral respiratory tract infection, every urinary tract infection, and every long-term prescription renewal for which the patient seeks care. This policy could

paradoxically *increase* the risk to patients, as the primary care provider misses critical communications while being inundated with records of trivial encounters.

Moreover, we have concerns around the expectation that walk-in clinics provide primary care to patients who lack a family physician. CPSO writes that, "physicians practicing in a walk-in clinic are advised to offer, where their scope of practice permits and in coordination with other physicians in the practice, comprehensive primary care to the patient as an interim measure" (goo.gl/RPVQDS, lines 108-112). To begin with, the provision of primary care is properly a matter of negotiation between the OMA and the government of Ontario. High-quality primary care requires an ongoing relationship with the patient that cannot be substituted for by a walk-in clinic that often employs a rotating roster of part-time physicians. Although many aspects of primary care can be offered safely and appropriately by walk-in clinic physicians, walk-in clinics are insufficient to correct the structural shortage of primary care providers. Ensuring every Ontarian has access to proper primary care requires cooperation and negotiation between the OMA, Canada's medical schools, and the Government of Ontario. Patients do not deserve, and are ill-served by, interim episodic care that lacks the comprehensiveness of true primary care. This aspect of *Continuity of Care* will only validate such a ***suboptimal*** approach to primary care needs across the province.

What becomes of the patient offered a fecal occult blood test who months later turns out to have metastatic colorectal cancer, requiring community based palliative care? Or the victim of sexual violence, that takes months to develop a trusting relationship with a care team? How is that vulnerable patient served by a different urgent care physician each month? Patients who have lacked a primary care provider for years do not need interim answers. They need structural changes in the health care system itself.

Finally, we have concerns around the requirement that consultant physicians respond to referral requests, "no later than 14 days from the date of receipt" (goo.gl/CBt8Ph, lines 195-196). This arbitrary timeframe will be difficult for many specialists to meet due to logistical factors (i.e. physician has partial presence in several settings, vacations) and patient factors (i.e. unreturned phone messages, incorrect contact information). The policy also demands that, "referring physicians must communicate the estimated or actual appointment date and time to the patient unless the consultant physician has indicated that they have done so or intend to do so" (goo.gl/CBt8Ph, lines 214-216). This shifts the administrative burden of specialist appointments to community family doctors that already struggle with a lack of time and resources. Taken together with the expectation that, "consultant physicians must communicate any instruction or information to patients that they will need in advance of the appointment…" (goo.gl/CBt8Ph, lines 216-217), the policy might even be seen as self-contradictory. The College expects the family physician to act as go-between for patient notification of the appointment details, yet expects the consultant to provide any preparatory information to the patient directly. This creates confusion over who bears final responsibility for the patient who is being prepared for the consultation. As the office of the specialist/consultant physician is best positioned to provide preparatory information to the patient, and make any last-minute appointment

adjustments, we would encourage the policy put the onus of appointment notification on the office of the specialist.

We agree with the need to improve both quality and access of care to the people of Ontario. However, the *Continuity of Care* policy in its current form is a threat to those goals. We reiterate our sincere worry that the policy will bring about unintended consequences: doctors burning out prematurely; doctors changing their scope or setting; doctors abandoning primary care; doctors leaving already underserviced communities; or doctors leaving and avoiding Ontario to begin with. Our district covers much of Southwestern Ontario, a region dotted with many smaller towns and communities. The potential consequences to our patients, our colleagues, and our communities are significant. Those consequences are also by and large harmful, in an area of the province unable to cope with any further deterioration in local health care services.

We understand that the OMA has provided similar feedback to this letter. We implore the College to engage the profession in further dialogue, and amend the *Continuity of Care* suite of policies to the benefit of all Ontarians.

Sincerely,

Dr. Sharadindu Rai, Chair, District 2, Ontario Medical Association

Dr. Silvia Orsini, Director, District 2

Dr. Nadia Brown, Secretary and Delegate, District 2

Dr. Lisa Dalby, Delegate, District 2

Dr. Catherine Frederick, Delegate, District 2

Dr. Tatiana Jevremovic, Delegate, District 2

Dr. Maryna Mammoliti, Delegate, District 2

Dr. David Pugh, Delegate, District 2

Dr. Vaishnav Rajgopal, Delegate, District 2