The College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario
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February 2, 2018

Attention: Policy Department: *Prescribing Drugs* Policy Consultation

To Whom It May Concern:

The Section on General and Family Practice of the Ontario Medical Association (SGFP or Section), represents over 12,000 practicing general physicians and family doctors in the province, and is the largest clinical Section within the Ontario Medical Association, comprising almost 1/2 of the total membership.

As the College begins to revise its policy on *Drug Prescribing*, the Section would like to offer the following general and specific comments.

General Comments

We juxtapose one of the key guiding principles articulated within this policy statement I.e., the need to *act in the patient's best interest* against the College's insistence articulated further in the policy statement that *" drug therapy must be stopped, following appropriate protocol, if it is not effective, or the risks outweigh the benefits."*

We would request the College reflect on the word "must" which may precipitate a decision or outcome (eg., refuse to provide or continue a prescription) right then and there at the time of a particular visit. We would suggest this may not be be in the patient's best interests.

To elaborate, there may be exceptions to the CPSO-demanded outcome of refusing to either provide or continue a prescription and that the exception may be based on a difference of opinion between the physician and the patient with respect to the risk-benefit ratio, where the patient may feel the benefit outweighs the risk. Assuming the patient's assessment is not flawed or in error, (in which case the physician has a duty to act accordingly), acting in the patient's best interest might mean giving the patient time to do their own research or reflect on their physician's advice. By allowing some flexibility over a short period of time, rather than precipitating a decision right then and there, we may be able to avoid what the CPSO is alluding to in its policy statement i..e, that patients dissatisfied with the decision seek their medication needs elsewhere.

Hard and fast rules applied by the College risk jeopardizing the ongoing therapeutic relationship between family doctor and patient. The therapeutic relationship we build between ourselves and our patients, which is built on trust and respect for patient autonomy, allows us to continue to assess and

monitor the patient and provide further education thereby guarding against patients seeking their needs elsewhere. Maintaining this therapeutic relationship is particularly important if there are inadequate resources available elsewhere (eg., pain management services, physiotherapy, counselling, etc) to meet the patient's needs.

So we would urge the College to reconsider the use of 'must' in its recommendations in favour of a more flexible approach that is still grounded in clinical judgement but is also respectful and protective of the therapeutic relationship between the family doctor and their patient.

Comments related to Specific sections of the policy document:

1) Page 2 **"Principles"** while we acknowledge what the College is saying with respect to electronic prescribing and electronic information systems, it should be recognized that currently, not all physicians are EMR-enabled and that physicians still retain the right to choose between paper charts or EMRs for their office practices.

2) Pages 3 and 4 **"Assessment"** notes that physicians can rely on an assessment done by someone else if the following conditions are BOTH met:
    a. They have reasonable grounds to believe that the person conducting the assessment has the appropriate knowledge, skill and judgment to do so; AND
    b. They obtain the assessment information from that person.

    Family doctors would interpret this to mean that person's actual notes. While specialist consultants do send notes, there may be some delay when we actually receive them.

    It should be noted that family doctors often see patients returning from a consultant referral that the family doctor has initiated, or the patient is now coming to us having been seen in Emergency and an accompanying consultation / assessment / discharge note is not yet available. In this instance, family doctors tend to proceed with the information that the patients are presenting at that time (eg., new script) as there may be difficulty getting the discharge summary or consultant note at that precise time. If they do not have the requisite information in hand, family doctors must conduct their own clinical assessment or try to chase down the consultant either by phone call or fax which increases our workload and decreases patient access to us.

    The above scenario suggests therefore, that at times, the College's dual conditions, may not be practical due to factors beyond the family doctor's control but that the family doctor will then accommodate for that using their own clinical judgement.

    Second point under 'Assessment"

    The College's dual conditions above, complicate team-based care. How would the College's recommendations impact RNs working in teams or under physician supervision? Could a pre-signed script via directive for UTI , for example, be provided without a physician assessing the patient directly? In certain team-based practices, it is expected that the family doctor simply writes the prescriptions needed without assessing the patient, because we trust our colleagues and trust our patients. Satisfying both conditions above, risks a potential delay in treatment. For

this reason, we would request the College exercise discretion in how it interprets physicians meeting these dual conditions.

3) Page 4 **"Diagnosis"** states physicians should make a decision to prescribe based on their determination of risk-benefit.

   Physicians will do that almost all the time but, there may be instances where there is a difference of opinion between the patient and his/her family doctor on what constitutes risk-benefit. For example, where the physician has recommended lowering the dose of thyroid medication based on blood work but the patient feels the current dose is working well for them including energy levels and may recall that previous dosage changes didn't work well for them, for one reason or another, and therefore, directs the physician to not reduce the dose. In these instances, physicians may choose to prescribe or renew medications at the existing dosage because the patient has elected to accept any and all risks associated with the provision of that prescription and both parties have agreed to monitor the situation moving forward. This is part of the therapeutic relationship between the family doctor and the patient that is built on trust and respect for patient autonomy.

4) Page 4 **"Informed Consent**" (and several other sections), requires physicians to advise patients about the material risks, benefits of the drug being prescribed, including its affects, interactions, contraindications, precautions and any other pertinent information. We understand the College's intent behind this statement but would like to emphasize that the increasing prevalence of pharmacy printouts provides a valuable and efficient patient education tool that should be recognized and encouraged by the College.

5) Page 6 **"Verbal Prescriptions":** the College needs to clarify in what clinical settings, its recommendations related to verbal prescriptions apply. For example, it is unclear whether physicians can or cannot continue to verbally prescribe narcotic meds for their patients in a Nursing Home or Home for the Aged, even if the prescription is given verbally only to be transcribed by an RN and to be signed off by the MD at a future time.

6) Page 8 "**No refill policy"**: We want to ensure that CPSO policy does not prevent the physician from refusing to refill a prescription when their clinical judgment is telling them that the patient needs to book an appointment for reassessment and renewal. How will the CPSO view this?

7) Page 9 "**Drug Samples"**: *"Share information about drug samples with other health care providers, as appropriate".* This comment is unclear and CPSO needs to clarify what it means by this statement.

8) Page 10 **"Narcotics Prescribing**" - There is an expectation that physicians will consult relevant practice standards and guidelines, narcotics dispensing databases, etc when prescribing narcotics and controlled substances. While we understand the College's emphasis on this class of drugs, we offer the following comments:
   a) This advice places a big requirement on physician time. Consulting where appropriate, implies having the resources, including appropriate funding, to consult these data sources.

b) This policy in effect mandates family doctor participation in HQO's primary care practice report. This is currently voluntary.

c) We are unsure but hope that 3 (ii) in the College's policy statement with respect to narcotics monitoring systems is based on some field testing where the value of these systems has been shown.

9) Page 12 "Double Doctoring" The College is naïve to think patients double-doctoring will admit this – thereby leaving the onus on the physician to figure this out or not. And although the expectation is on the physician to ask the patient whether they are double doctoring, there is no requirement on a pharmacy to let the physician know when they see that the patient is double doctoring. The College should negotiate this expectation with the College of Pharmacy.

We trust you find these comments useful.

Should you have any questions, please contact us at sgfp@oma.org