November 23, 2018

The CPSO is presenting a draft consultation for Continuity of Care that has elements that are of concern to rural hospitals. We recognize that continuity of care is an important principle, but how it is achieved by individual physicians varies depending on the competing demands for their services. From the consultation:

*Coordinating After-Hours Coverage for Patients*

Primary care physicians and specialists providing care as part of a sustained physician-patient relationship where care is actively managed over multiple encounters must have a plan in place to coordinate care for their patients outside of regular operating hours. This is often referred to as after-hours. The nature of the plan will depend on the time of day and type of day (i.e., weekday, weekend, and holiday), the needs of their patients, as well as on the health-care provider and/or health system resources in the community. Physicians must use their professional judgment to determine how best to structure their plan and must act in good faith, making a reasonable attempt to minimize uncoordinated access to care and the inappropriate utilization of emergency rooms or walk-in clinics.

*Facilitating Access to Appointments*

Treating patients as part of a sustained physician-patient relationship facilitates continuity of care, which improves patient health outcomes. It is ideal for patients to see physicians with whom they have a sustained physician-patient relationship for care that is within their physician’s scope of practice, rather than relying on walk-in clinics or emergency rooms.

In order to facilitate timely access to care and continuity of care, physicians must structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues. This may include implementing a same-day scheduling system or utilizing other physicians or health-care staff within or outside their practice.

This proposal is vague (“depending on health system resources in the community”) and leaves physicians who provide much needed services at our rural hospitals at risk of college sanction, where it is in fact appropriate and a necessity of physician resource management to be absent from their offices for these purposes. Rural emergency departments are staffed by the very same family doctors who service the offices and who are absent from their offices often as a result of their services in hospital. Often ALL the inpatient care (24/7) is done by those same GPs. In many hospitals the same doctors are doing inpatient, ER and office care (among many other things) and the physician resources are stretched thin. They are the same
group who will cover LTC facilities and provide the clinical leadership support to the hospitals (Chiefs of Staff, Department Chiefs).

From the perspective of the chief of staff of a rural hospital the proposed continuity of care policy is a significant threat to the viability of rural hospitals. We have already seen the push to after hours clinics and increased expectations of availability in offices lead to a concurrent drop in family doctors providing hospital services; inpatient care, OR assists, ER service, rural obstetrics. Rural Ontario hospitals cannot survive without the integral involvement of family doctors. Yet their time commitments in hospital and their critical role are not recognized in this proposal, which does not differentiate rural from urban situations and contexts. We need these doctors in our hospitals, in our emergency departments, our inpatient wards, and our operating rooms. Facing threat of college sanction now if not providing timely office coverage, we fear less and less family doctors will be willing to provide these services and our hospitals will suffer. Many of our local rural colleagues are already talking of pulling out of ER shifts to attend their after hour clinics. Some rural hospitals are struggling to find OR assistants. Other physicians are speaking of closing their practises, so as to not face this threat of college sanction, and work only in hospital facilities, something many new graduates are choosing to do. While this may keep our hospitals viable it will not serve our patients well.

As Chiefs of staff we see a level of distress and burnout amongst our colleagues that is deeply concerning. While this document makes a vague reference to placing value on physician health, the expectations therein will only serve to contribute to this distress. This policy places the burden on the individual physician to set systems up to provide these services, rather than compelling policy and governments to set up sustainable systems.

We request that the CPSO make very careful consideration of the realities and differences of care provided in different communities and make a document that recognizes the integral role of family doctors in rural hospitals, while truly placing value on physician health. In rural communities, these systems of care currently work well and our hospitals are reliant on them.