Registrar/CEO
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Dear

Re: CPSO Continuity of Care Policies

The Canadian Medical Protective Association ("CMPA") appreciates the opportunity to comment on the College's "suite" of draft policies related to continuity of care, including the foundational policy "*Continuity of Care"*, and the four companion policies *"Availability and Coverage"*, "*Managing Tests"*, "*Transitions in Care"*, and "*Walk-in Clinics"*.

As the College is aware, the CMPA is a mutual defence organization whose mandate does not include establishing or endorsing standards of practice. The advice the CMPA provides to members is principally risk-management based. Although we are aware of the broader discussion in the medical community around these policies, the CMPA's comments are intended to focus primarily on those aspects of the draft policies that might give rise to medical-legal and patient safety concerns for Ontario members.

Physician Wellness

We are aware of the concerns expressed by some that the expectations imposed by the draft policies will create additional administrative burden and significantly increased workloads for some physicians. The CMPA encourages the College, when finalizing the continuity of care policies, to ensure they do not expressly or inadvertently impose or imply a standard of perfection. Rather, the articulation of realistic expectations that appropriately recognize the challenges providing care in the context of scarce resources will help reduce physician stress and concern regarding the policies.

While the CMPA's mandate does not typically include commenting on the administrative aspects of the practice of medicine, we are mindful of the potential effects a physician's physical and mental wellbeing can have on patient safety and quality of care. As you know, heavy workloads, increased administrative demands and inadequate resources, amongst other factors, are known to contribute to a deterioration in physician wellbeing. The empirical evidence is that physicians who are physically and mentally unwell are less likely to practise effectively or safely. It is for these reasons that the CMPA published the paper, "*Healthier physicians: An investment in safe medical care*", and devoted the Information Session at our 2018 Annual Meeting to the topic of physician wellness.

In addition to other stakeholders, including the CMPA, medical regulatory authorities have a key role to play supporting physician health. It is helpful in this regard that the CPSO has recognized the potential effect of physicians' health on the delivery of care, including as follows in the "*Practice Guide: Medical Professionalism and College Policies":*

> Because physicians cannot serve their own patients if they are not well, physicians may have to put their own needs for wellness ahead of the needs of individual patients or the public as a whole in some circumstances. Physician wellness is also important for its own sake independent of any responsibility to others.

We agree there are system-level factors that can contribute to continuity of care issues, the solutions to which are beyond the control of individual physicians or the scope of this consultation. We understand the College intends to publish a white paper with recommendations on these broader systems issues. While such a paper will assist in advocating for necessary and important system changes, in the meantime the CPSO might consider changes to the draft policies as part of the current consultation to reflect better the realities of our health care system and the challenges for physicians working with limited resources.

There is no disputing that physicians' duties to their patients include implementing measures to ensure appropriate continuity of care. The College's expectations and standards for physicians to achieve this objective should, however, reflect the standard of reasonableness as confirmed by the courts. In this regard, courts have consistently stated that an assessment of a physician's clinical care is not based on a standard of perfection, but rather the standard of care that might reasonably be applied by a colleague in similar circumstances.

Critical Test Results

The CMPA recommends retaining the more reasonable expectation set out in the existing *Test Results Management Policy* that physicians "take appropriate action and follow-up with the patient with appropriate urgency."

It is widely accepted that the failure to follow-up on critical test results can result in poor clinical outcomes for some patients. However, we are concerned by the onerous and unrealistic expectation in each of the companion draft policies that physicians who order tests "must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week."

While it is reasonable to expect physicians to have a system that allows them to receive test results at any time of day, it is impractical to expect physicians to take action regardless of the hour of the day or night and without consideration for the clinical circumstances. We appreciate that the draft policies acknowledge that physicians ordering tests do not necessarily need to make *themselves* available at all times to respond to critical results. However, the policies as currently worded would appear to require physicians to make coverage arrangements for those times when they are unavailable. This requirement fails to recognize the practical challenges associated with making such arrangements at times when many physician colleagues are also unavailable to action a critical test result (*e.g.* middle of the night) or for those who practice in remote and rural areas where coverage arrangements can be challenging.

The existing *Test Results Management Policy* states that physicians should "take appropriate action and follow-up with the patient with appropriate urgency." Not only is this expectation more achievable and practical for physicians, it also appropriately recognizes that not all critical test results need to be treated with the same level of urgency. Indeed, some test results may be considered critical by the laboratory processing the sample, but might not require immediate action once considered by the physician in the context of other clinically relevant factors. For example, some patients naturally have lower-than-average neutrophil counts. In these situations, a test result confirming neutropenia may not need to be actioned immediately.

Tracking Test Results

The draft *Managing Tests Policy* would require physicians "to verify that the patient has had the test" as part of their tracking system for high-risk patients and where test results are not received. Such a requirement is practically infeasible and could be viewed as counter to the principles of patient autonomy on the basis that some patients may subsequently decide not to undergo the ordered test.

Discussing with patients the clinical significance and rationale for an investigative test can help increase the likelihood of patient follow through and compliance. It is particularly prudent to do so and to follow-up more closely with patients suffering from a potentially serious condition or when ordering a test expected to produce a clinically significant result.

While it may be reasonable to expect physicians to follow-up with patients when test results are not received when expected, it should not be the responsibility of the physician to verify that the patient actually attends for the test. Indeed, patients have their own separate duty when seeking medical treatment to follow instructions and generally act in their own best interests.

Test Results Management System

The CMPA recommends the draft *Managing Tests Policy* more clearly articulate the College's expectations regarding the actions physicians should take when encountering deficiencies in test result management systems not within their control.

Similar to the current *Test Results Management Policy*, the new draft *Policy* states that physicians must have an effective system to manage test results that enables them to carry out a variety of tasks (*e.g.* record all tests ordered, record all test results received and reviewed, *etc.*). Unlike the existing *Policy*, however, the draft *Policy* suggests physicians who are not responsible for choosing the system must nevertheless be satisfied that it has all the specified capabilities. It fails to offer physicians any guidance or suggestions on the steps they might take with their hospital or clinic administration if the system does not have all the specified capabilities.

The CMPA typically advises members in these circumstances to communicate their concerns to the appropriate hospital or clinic administrators, preferably in writing. Consideration might be given to including similar advice in the new *Policy*.

Receiving Test Results Incidentally

The draft *Managing Tests Policy* addresses situations in which a physician who did not order a test receives a result in error or otherwise becomes "incidentally" aware of a critical or clinically significant test result (*e.g.* by being copied on a report). It states that physicians in those circumstances should make reasonable efforts to inform the ordering clinician, the patient and the laboratory where the physician has "reason to believe the ordering health care provider did not or will not get the test result". Physicians might benefit from further guidance from the College about the types of circumstances in which a physician may believe that the ordering physician did not or will not get the result, beyond when the ordering physician is known to be deceased or retired. Otherwise, physicians may feel obligated to follow-up with the ordering physician or patient *anytime* they are copied on a test result. There is generally no confirmation provided to the physician copied on a test result that the ordering physician in fact received it and will follow up with the patient.

Scheduling Appointments with Consultants

The CMPA encourages the College to amend the draft *Transitions in Care Policy* to require consultant physicians to communicate directly with the patient regarding the appointment details. Consultant physicians should also notify the referring physician of the appointment date so that the referring physician can determine if the timing is cause for significant clinical concern.

As currently written, the draft *Policy* would require referring physicians to advise the patient of the estimated or actual appointment date with a consultant physician, unless the consultant physician has indicated that he/she has already done so or intends to so. It is expected many physicians will not necessarily be aware of the estimated or actual appointment date set by the consultant. Moreover, such a requirement creates an unnecessary burden on referring physicians and could lead to patient safety issues.

Consultant physicians are generally responsible for communicating to patients the appointment date and time. This allows patients to confirm their availability and minimize the potential for missed appointments. It also permits consultant physicians to clarify important details with the patient about the appointment (*e.g.* special instructions, important information, *etc.*)

Tasking referring physicians with the responsibility of communicating to patients appointment details with consultant physicians creates increased risk for miscommunication, potentially leading to patient harm. It should generally not be the responsibility of the referring physician to provide this information to the patient. In many cases, the referring physician will not have the requisite knowledge to communicate these important details or answer any questions the patient may have regarding the logistics or special instructions for the appointment.

Acknowledging Referrals

The draft *Transitions in Care Policy* states that consultant physicians who are not able to accept an urgent referral "must provide suggestions to the referring health-care provider of alternative health-care provider(s) who may be able to accept the referral". The CMPA suggests it would be more reasonable and practical to require consultant physicians to provide alternative suggestions, where possible.

CWhile it is obviously important from a quality of care perspective for consultant physicians to recommend other providers who may be able to accept the referral, the draft *Policy* does not take into account circumstances in which the consulting physician is not in a position to provide alternative suggestions. For example, there may be no other consultant physicians accepting referrals or the consulting physician may be the only physician who practices in that particular speciality.

I trust the above comments will be helpful in finalizing the draft policies on continuity of care.

Yours sincerely,

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