Availability and Coverage

"Being Available by Telephone: Physicians must have an office telephone that is answered and / or a voicemail that allows messages to be left during operating hours *and a voicemail that allows messages to be left outside of operating hours*."

Whilst I agree that it is essential to have an office telephone that is answered, we have had to discontinue our voicemail due to the significant adverse effect it was having on availability, as well as the unfortunately abusive messages people left on a regular basis and their impact on our staff. Having a voicemail option resulted in our receptionist spending hours listening to messages, returning messages and playing phone tag in an effort to provide availability and continuity. While spending time on that task, she would miss incoming calls and there were longer waits at the window if she was in the middle of a call. In addition, she was exposed to rude or abusive messages on a weekly, if not daily basis. This had a significant impact on staff morale, and presented challenges with staff retention. We moved away from having a voicemail in an effort to improve exactly the kind of availability and continuity this draft policy is aiming for. Going back to such an inefficient model will simply result in the same problems resurfacing. In addition, we will not be able to retain staff. From experience, I can say with confidence that the best way to optimize availability and continuity of care has been to discontinue the voicemail. Our patients have repeatedly told us how much easier it is now to speak with the receptionist or book an appointment.

"Coordinating After-Hours Coverage for Test Results: Physicians who order tests must ensure that *critical* test results can be received and responded to *24 hours a day, 7 days a week*."

In the context of a family physician, who does not work in the emergency department, this is not really appropriate. Any tests that I order are ordered on outpatients, rather than patients in a critical condition. If a patient were to do a test that unexpectedly yielded a critical result, primary care is not the appropriate setting for follow up. For emergencies such as these, patients should be seen in an emergency setting where there is access to the required treatment – IV treatments or even rehydration is not available in a primary care setting. In addition, it is not realistic to expect that every family physician is to be essentially "on call" 24 hours a day, 7 days a week. Clearly this would compromise physician health, and deter people from going into family medicine. Continuity of care should take place in the most appropriate clinic setting, and for critical results, primary care is not the appropriate setting.

Managing Tests

"Physicians *must track test results for high-risk patients* to ensure that their test results are not lost or missed... they *must follow-up with the patient to verify that the patient has had the test* and / or *follow-up with the laboratory and / or diagnostic facility to verify that the laboratory and or diagnostic facility has the test result*."

I have two concerns with this policy. The first concerns what exactly is meant by "high-risk patients", as the definition is somewhat ambiguous. The policy defines this as "patients who present with serious clinical symptoms, who have been diagnosed with a life-threatening illness, or who have been identified as high-risk by their physicians." By this definition, all of my diabetic patients could potentially be classified as "high-risk". It is simply not reasonable or practical to check with patients / labs / diagnostic facilities that every test ordered on these patients has been done, and the result received. With my clinical duties, maintaining continuity of care, optimizing availability and coverage, and managing the huge number of test results and specialist reports that come in on a daily basis, checking with patients if they have done the requested test as we have discussed is simply not feasible. As a small business, my colleague and I employ two staff who are kept very busy with coordinating the clinical care. In order to check if patients have done all the tests ordered, we would require additional staff. As there is no support in this regard for family doctors, in the way there is for midwives for example, this is simply not a financially viable option for a small business. It is important not to underestimate the need for patient responsibility for their health, and the value of their input in contacting us if they have not heard / followed up on a test that was ordered.

Transitions in Care

"Referring physicians must have a mechanism in place to track that the referral has been received and that an acknowledgment of the referral with be provided."

Whilst our system does track that the referral has been sent and when, we do not receive confirmation of receipt of the referral from most specialists. I note in another area of the draft policy that the recommendation is for specialists to provide confirmation of receipt of referral within a couple of weeks. Until such time as that is received, we are unable to track this any more closely.

"...when making a referral for the purposes of a test, referring physicians must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week."

This is subject to the same comments as under "Coordinating After Hours Coverage for Test Results" above.

"Referring physicians must communicate the estimated or actual appointment date and time to the patient unless the consultant physician has indicated that they have already done so or intend to do so."

Given the workload of family physicians' offices currently, if we are to maintain continuity of care, availability and coverage, we are unable at this time to add the booking of specialists' appointments to this workload. Staff spend significant time every day with booking our own appointments, and there is simply not the availability to provide clerical services for specialists in addition.

Walk-in-Clinics

"Physicians practising in a walk-in clinic must provide the patient's primary care provider, if there is one, with a record of the encounter."

This would certainly be useful. As a family physician working in a FHO, the only thing I receive if a patient of mine is seen in a walk-in clinic is a bill. I fundamentally disagree with being penalized for patients choosing to access walk-in clinic care when there is availability at their family doctor's office. If the patient does not even call, we cannot be any more accessible.

I trust that you will take these "real life" factors into account when making / enacting new policies.