Dec. 9, 2018

*****

The College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON
M5G 2E2

RE: Proposed Continuity of Care Policy

Dear Registrar,

As a rural family physician who has been in practice for almost 16 years, and who has paper charts, here are some thoughts on the College's proposed Continuity of Care policy.

MANAGING TESTS:

- I firmly believe that patient's need to be accountable for their health. And, the extra staff that would be required to track whether or not patients get their tests done would make family practice unaffordable for most physicians. Staff already waste huge amounts of time on patients who change cell number and don't tell us. Or whom we call over 10 times, send 2 letters to, and who still don't respond. Why is this the physician's responsibility? It will lead to fewer people practicing family medicine, and less access for patients.
- A test management system is perhaps an option in an EMR. However, with paper charts this is a much bigger challenge, and much more time consuming. And, what do you mean by "high risk patients"?? I believe all good physicians book a follow up for anyone we're truly concerned about, if not leave the chart out until results arrive. But, if the patient doesn't show for his/her follow-up, doesn't answer his/her phone, or respond to letters, why is that all my responsibility??
- Why should I be available to the lab 24/7?? If I'm available 24/7, I can never have a drink and I can never be out of cell service (and I currently have a cottage with no cell service). I would quit family medicine tomorrow. I went into family medicine for many reasons, but one was so I could sleep at night. I do not function without a good night's sleep – and I am no good for myself, my family, or my patients if I'm exhausted. If the lab has a critical result – number one check the patient's history to see if this is actually a change for

the patient?? Can this not be done through OLIS? And two, if there's a critical result, can the lab not hire a physician to be on call to deal with it?? (Or could the province improve Telehealth so that there's a physicians on call?) Or just send the patient to the ER. Me being on call 24/7 means I will no longer be a family doctor. And, working where I do, that likely means all my patients will no longer have a family physician. 24/7 availability makes avoiding burnout impossible.

- I do NOT want to be copied on every test that every specialist orders on my patients. I won't be able to keep up with the mail, and the important things may get missed. The extra time spent dealing with mail may lead to less time face-to-face with patients.
- Follow up of test results should always fall on the person who ordered the test. I often do not know anything about a test a specialist orders, let alone whether a slight abnormality is significant or not. I actually do not even want to be copied on the test, as I cannot accurately interpret the results. What I would like is a good, timely consult note telling me what tests were ordered and whether any of the results were significant. The CMPA also tells me that I am somewhat responsible for any test result that is copied to me. This means that I then have to research every slightly abnormal test arriving in my mail. And, due to volume of mail and lack of time in the day, the more paperwork crossing my desk, the more likely I am to decrease the number of hours that I actually see patients – reducing access to care.

AVAILABILITY AND COVERAGE:

- Having voice mail after hours puts patients AT RISK. Physicians can't check voice mail regularly after hours and avoid burnout. So, messages will be left for up to 3 or 4 days on a long weekend. Patient's may assume that they are being listened to regularly (despite a message saying they won't be heard until the next business day), and not go to ER when in fact that is where they should be in some cases. Even a delay of a few hours could be life threatening in some situations. If issues after hours, patients should call Telehealth. During the day physicians should answer their phones. This is safest for patients.
- Working in northern Ontario, the supply of locums is hot and cold, and finding one is often a challenge. We are 2 physicians in my office. We cover for each other often. But, after hours the only sustainable solution is for patients to go to the ER. We cannot work 24/7. In fact, I struggle to see patients 4-1/2 days a week, do my paperwork and survive. The extra work is overwhelming at times. The patients are overwhelming at times. I need regular vacations to survive – and if I cannot find a locum (and was required to by the College to do so) I would quit. I would become the locum physician – who is actually able to sleep at night and stay healthy.

TRANSITIONS IN CARE:

- Specialists should book appointments with patients – NOT the referring physician. This is far too much work to place on family physicians primarily. And, the extra staff required to book all these appointments would make family medicine offices unaffordable. Physicians will leave family medicine, and medical students won't choose family medicine … both leading to a decrease in access to care.
- If specialists want me to see a patient a week after hospital discharge, then the discharge note should be available before my follow-up appointment. Otherwise, what's the point of the visit??
- 30 days to get a specialist's note is TOO LONG. If the specialist is changing my patient's medication, or making management suggestions that the patient may have misunderstood (and I find patient's misunderstand what the specialist has recommended often), then I need that note much sooner – ideally within a week, but 14 days would be acceptable if no significant changes recommended. Many specialists now fax their reports to my office within 24-48 hours, which is amazing. I would also question the quality of a note dictated by a specialist 2-3 weeks after seeing the patient – how much of the visit do they truly remember?? Is a note dictated 2 or 3 weeks later truly of any value to me?? Are there mistakes in it?? (Patients often tell me things that are contradictory to what is written in the report – who is right??)

WALK-IN CLINICS:

- My volume of mail currently is very time consuming – and since many of my patients are sick and old, most of my bloodwork has abnormal results that require me reviewing the chart. If the volume of mail were to increase much more, ie. due to receiving a copy of every visit to a walk-in clinic, at some point I would have to cut back on the number of hours I see patients. There just are not enough hours in the day. Currently, 6 hours of face-to-face patient care leads to at least 3 hours of paperwork. Studies are now showing this can be as high as a 1:1 ratio – at which point my 6 hours of patient appointments will lead to a 12 hour day and I would be forced to shrink the size of my practice (leaving orphaned patients). I also fear that as the volume of mail increases, there is a risk that the truly important information gets lost in the sea of not useful reports. I really do not feel that receiving a copy of every walk-in clinic visit for a UTI, a sore throat, a sore back, or a sprained ankle adds anything to the care of my patient. What I do want to receive is any change in my patient's medication, or a copy of any visit that would affect future management (or course only if my patient is agreeable to this sharing of information).

I hope these comments are helpful. Please do not hesitate to contact me if any questions.