Ontario College of Family Physicians

Leaders for a healthy Ontario

January 30, 2025

To: College of Physicians and Surgeons of Ontario (CPSO)

Re: Treatment of Self, Family Members, and Others Close to You; Accepting New Patients; and Ending the Physician-Patient Relationship policy consultations

The Ontario College of Family Physicians (OCFP) represents more than 18,000 family physicians and medical students, including residents, retired family physicians, and more than 15,000 who are working in communities providing care to patients. Our members care for Ontarians across the health system, in primary care offices, hospitals and emergency departments, urgent care centres and walk-in clinics, as well as through home and long-term care, palliative care and more.

Below is the OCFP's feedback on the three current policy consultations underway. Should additional clarification be helpful, we would be pleased to discuss our comments further.

1. Treatment of Self, Family Members, and Others Close to You

General feedback

- Neither the policy nor advice document contemplates a common issue in a rural context: the treatment of clinic employees. There are challenges with providing care to patients that have an employment relationship with their physician, or to providers who play an essential health human resources role in a community. For example, physicians may be in a challenging situation in being asked to provide documentation to a nurse seeking stress leave, when they understand the impact this will have on accessing health services in the community. At minimum, it would be helpful to incorporate employee/employer or dependent working relationships in the policy and/or advice document(s).

- There appears to be a contradiction between the policy and advice regarding the prescribing of controlled substances to family members, or others close to them. Lines 102-107 of the policy state that physicians must not prescribe or administer controlled substances to family members, or others close to them. However, in the advice document, lines 125-130, physicians are advised that they can prescribe controlled substances if they are providing treatment, for example, in an Emergency Department. Clarification would be helpful for what appears to be an inconsistency between the policy and advice.

Advice to the Profession

Lines 55-68 outline why physicians are not permitted to treat sexual or romantic partners.

- This section would benefit from greater clarity, in layman's language, as to why treating a sexual or romantic partner may lead to a finding of sexual abuse under the *RHPA*.

2. Accepting New Patients

Policy

General feedback

Family physicians have raised concerns about specialists declining a referral due to long waitlists without considering that they may be the only appropriate specialist in a geographic area for managing the condition of the referred patient. It would be beneficial if the policy contained an expectation for specialists to consider access to care for specialized services prior to declining a referral.

Specific feedback

Section 4.a) establishes criteria for accepting new patients within a physician's clinical competence, scope of practice, and/or focused practice area.

- Academic family medicine teaching practices typically require a certain mix of patient populations to serve the educational needs of trainees, and this is not captured in the existing expectation.
- It is therefore suggested that lines 44-45 be revised as follows, "Be directly relevant to the physician's clinical competence, scope of practice, and/or focused practice area, and their responsibility to institutional requirements where appropriate (e.g. academic teaching practices that require a certain mix of patient populations)."

Section 4.d) and e) states that physician criteria for accepting new patients must be "clearly communicated to any prospective patient…and shared with CPSO, on request".

- Some family physicians have expressed concern that the policy appears to imply the need to document criteria for accepting new patients, but no explicit expectation or recommendation is in the policy. If there is an expectation or recommendation to document criteria for accepting new patients, this should be stated.
- Some family physicians have spoken to the value of balancing a practice between higher and lower needs patients to ensure that complex patients are well served and to prevent physician burn out. However, it is unclear from the policy whether this could be done in a way that would meet CPSO's expectations – any potential for clarification would be welcome.

Section 6, lines 58-61 set out expectations for primary care physicians in managing the patient's healthcare needs outside of the physician's clinical competence and/or scope of practice.

- While it reasonable to ask a physician to make a referral, there is no definition provided on patient abandonment (as referenced in line 59).
- It is also unclear as to how this expectation relates to the Accepting New Patients policy rather than the Ending the Physician-Patient Relationship policy.

Advice

General feedback

- Some specialists may not consider a consult "accepting a new patient" and greater clarity and emphasis on the policy's relevance to all physicians would be beneficial.

- It would be valuable to directly address the issue of whether physicians are permitted to limit their practice to those with OHIP coverage and how this may impact specific populations such as new immigrants and refugees.

Specific feedback

Lines 27-40 provide advice related to identifying "priority populations" and give common examples of those who may fall under this definition.

- Given the constantly changing nature of identifying priority populations, it would be helpful to indicate that there is a level of subjectivity in identifying these groups and that this is not a comprehensive list. The lens of social determinants of health may also be a more useful concept for identifying priority populations most at risk of experiencing health inequities than "marginalization".

Lines 44-47 provide advice related to communicating physician criteria for accepting new patients to those inquiring about joining a practice. The advice states that criteria for accepting new patients be shared "at the earliest opportunity, for example, during an introductory meeting or when the patient first inquires…".

- A suggested edit is to consider adding, "…with the latter option being preferred." to the above noted sentence. Patients may incur costs and inconvenience to attend an introductory meeting to learn after the fact that they do not meet the criteria set by the physician. Ideally, these criteria would be shared before booking or attending an introductory meeting.
- Family physicians have noted that any opportunity to provide practical tools or standardized scripts to share these criteria, would be welcome.

Lines 63 – 67 provide advice on how physicians can ensure their criteria are fair and equitable and that "all prospective patients receive equal treatment with respect to accessing health services."

- The current wording does not seem to consider that some priority populations may not be well served by "equal" treatment, and that equal treatment is not necessarily equitable. For example, accommodations may be required for certain priority populations to receive equitable treatment, such as those without internet access or the ability to line up for a chance to roster with a physician. More clarity on how to ensure equitable treatment of priority populations, and examples of potential accommodations, would be helpful for building non-discriminatory policies for accepting new patients.

Lines 107-114 provide advice related to patients seeking a second opinion, noting "It would be inappropriate, however, for physicians to practise medicine in a manner that hinders patient autonomy or limits patient decisions about the care they receive."

- This statement is somewhat vague and would benefit from greater clarity.

3. Ending the Physician-Patient Relationship

Advice

General feedback

- There are rural settings where there is only one primary care clinic serving the whole community. Any advice that CPSO could offer to physicians considering ending the physician-patient relationship in this context would be beneficial.

- Is there any advice to physicians in documenting or managing abusive or disruptive behaviour from a patient's support person (e.g., a parent of a patient, substitute decision maker, family member of someone with dementia or person requiring translation, etc.)?

Specific feedback

Lines 53-59 of the advice document note reasons why physicians may end the relationship and include "conflict of interest with the patient".

- What constitutes "conflict of interest" in the context of ending the physician-patient relationship is not defined. It is possible that some physicians may interpret this as a conflict of views related to MAID, abortion, etc. However, the advice document does not carry over the expectations laid out in the policy that prohibit physicians from ending the physician-patient relationship due to reasons of conscience or religion. It would be beneficial to clarify what constitutes a conflict of interest and provide examples in the advice document.

Lines 87-107 provide advice on de-rostering patients for seeking care outside of the practice.

- Physicians raised concerns that de-rostering patients and seeing them on a fee-for-service basis may impact the patient's ability to access the services of other healthcare providers in a family health team. It would be important to note in the advice document that physicians should be aware of impacting the patient's ability to access other healthcare services when de-rostering a patient.

- In this same section, physicians are advised to "consider the factors that may have led the patient to seek care outside the practice". Does CPSO recommend that physicians document this consideration?