Ontario Medical Association

Ontario Medical Association Submission

CPSO *Closing a Medical Practice* and *Consent to Treatment* Policies

November 2024

The OMA appreciates the opportunity to provide comments on the College's Consent to Treatment and Closing a Medical Practice policies and accompanying Advice to the Profession (Advice) documents. We have conducted a review of the policies and consulted broadly with membership through several channels. The feedback received is summarized below.

1) Closing a Medical Practice Policy

Policy

Planning for unexpected practise closures

Provision 1: It is stated here that "*physicians **must** take steps to proactively plan for unexpected practice closures due to death or illness so that their practice is managed appropriately and in compliance with this policy and physicians' legal obligations".*

Recommendation: It is recommended that the College more explicitly outline what this involves as extending this requirement to all points of the policy and planning for all contingencies on an ongoing basis would be impractical, highly burdensome and non-feasible for many physicians. A checklist with examples would be helpful to include within the Advice document.

Facilitating access to ongoing care following a practise closure

Provision 2: Provision 2 states that *"physicians **must** take reasonable steps to arrange for the ongoing care of patients when they close a practice, including instances where a practice is relocated, and patients are unable or choose not to move with the practice. What is reasonable will depend on the reason for the practice closure, patient needs, and the health-care providers and/or health system resources available in the community".*

Recommendation: The policy should outline when specifically the physician has discharged this duty as many physicians still feel responsible for caring for their patients once they have closed their practice, particularly if the patients are complex or high needs It would be helpful if the College would propose a length of time, and the OMA will consult with membership and provide feedback once the policy is released for consultation again.

Facilitating access to prescription medication

Provision 3: Here it is stated that "*where a renewal or repeat of a prescription is necessary to allow a patient a reasonable amount of time to find another provider, physicians who maintain their certificate of registration **must** provide a renewal or repeat when one is clinically indicated."*

Recommendation: Similarly to the recommendation above, it is recommended that greater detail be provided regarding how physicians should manage refills when there is no provider available to transfer the patient to and the patient is unable to find another provider as this is an issue that physicians often report struggling with. The policy should also address giving notice in the hospital context as this is not addressed within the current iteration of the policy.

Advice to the Profession Document

Arranging ongoing care

This section should address current healthcare access challenges more explicitly. The majority of physicians in Ontario are experiencing some level of burnout and this results in large part from health system demands downloaded to physicians who have no control over health system gaps and resource limitations, and no training in navigating these challenges. Being unable to meet patients' needs and inhibited by barriers far beyond an individual physician's abilities and control also contributes to moral injury.

As such, the term "reasonable steps" is too vague in the context of facilitating ongoing care, especially given the current shortage of available providers and lengthy wait times in Ontario, which can exceed 24 months. Additionally, it is unreasonable that the College appears to assign sole responsibility for patient access to individual physicians, when instead primary care assignments and specialist triage should be managed by the health system. Assigning this responsibility to individual physicians is both impractical and unfair and this section should be revised to reflect these important nuances. Perhaps a pre-amble acknowledging the burnout and moral injury currently facing physicians could be included here.

2) Consent to Treatment Policy

Policy

Recommendation: It is recommended that the link to the *Medical Record Management* policy should be linked on the Consent to Treatment policy webpage as the obligations within the medical records management policy apply to the Closing a Medical Practice policy as well and it would be helpful for physicians to refer to this directly.

Recommendation: The College should clarify when and how consent can be given "in advance," especially for more common treatments and surgeries. While the advice document mentions that if a patient becomes incapable, consent may need to come from the SDM, it would be beneficial to clarify this in the policy itself.

Advice to the Profession Document

Obtaining consent

Line 22: The question here states "*what should I consider in determining whether it is appropriate to use family members as interpreter"?* In the response, it is stated that "*physicians are advised to use a formal or third-party interpretation service where available"*. As written, this seems to suggest that a third party is preferable where available, however it is unclear what "where available" means and whether this is limited to a hospital setting where the physician can likely access this service easily or in the community as well where the physician would have to arrange for this service to be made available.

It is recommended that the CPSO clarify what is meant by "where available" and acknowledge the nuances around hospital and community physicians within the Advice document. Additionally, if this applies to physicians within the community, the Advice document should outline resources where physicians can access formal or third-party interpretation service.

Line 53-55: Here, regarding, if a signed consent form constitutes informed consent, it is stated "*Not necessarily, the requirement for informed consent will not be met where the patient simply signs a consent form or receives written education materials or pamphlets without a discussion of the expected benefits and material risks of the proposed treatment…".* As written, it is implied that written consent is not useful for the purposes of obtaining consent. If this is the case, this should be explicitly outlined. If this is not the case, it is recommended that the College clarify the role of written consent and provide rationale as to when a written consent form may be appropriate.

Line 75-86: The question here states that "*To obtain informed consent, I need to provide certain information, including the "material risks" associated with the treatment. What are "material" risks, and which risks do I have to disclose?".* It would be helpful if specific examples of material risks were provided in response to this question.

Determining Capacity

Line 87-98: The question here refers to whether the physician can assume that once a patient is considered capable with respect to a treatment, they will always be capable regarding that treatment or will be capable for all other treatment decisions. It is recommended that the Advice document also reference that a patient's capacity can fluctuate and may return, as a determination of capacity can change over time depending on the context. While this is covered in the Guide to the HCCA, it would be helpful to include it in the advice document, as this perspective is essential under the HCCA but is currently missing, requiring physicians to refer to the Guide for complete guidance.

The OMA appreciates the opportunity to provide feedback on the policies and the accompanying Advice to the Profession documents. Please contact us if you have questions or require additional feedback.