

Submission Before the Standing Committee on Social Policy on Bill 179 The Regulated Health Professions Statute Law Amendment Act, 2009

Introduction

Dr. Douglas Mark: Thank you for the opportunity to appear before you today. My name is Dr. Douglas Mark, and it is my privilege to serve as the president of the Coalition of Family Physicians of Ontario. Founded in July 1996, The Coalition of Family Physicians of Ontario is a voluntary member-driven, grassroots organization representing over 3,000 family physicians. It is dedicated to protecting the rights and independence of family physicians across the province. We advocate, on behalf of our patients and members, solutions to improve health care delivery to the people of Ontario.

Joining me today is Board member Dr. Felix Klajner who will present our main concerns today. Dr. Klajner?

Submission

Dr. Felix Klajner: Thank-you Dr. Mark. Thank-you again for this opportunity to speak to you today. We would first like to briefly review the historic background leading up to Bill 179.

Virtually no decision involving one area of health care can be made without affecting some other area either within the health care system or beyond it. For this reason, very thorough and thoughtful research and decision-making is required.

In the early 1990s, significant reductions were made to medical school training positions in Ontario, following recommendations of the Barer-Stoddard report at that time. Ontario and in fact all of Canada are still feeling the effects of this ill-fated decision, as our health care system struggles to provide access to patients in the face of severe shortages of physicians as well as nurses and other healthcare resources. Now, almost twenty years later, Ontario has made significant increases in medical training positions, in a sharp but commendable reversal of previous government policy. However, large gaps still remain, such as access to primary care physicians, specialists, and diagnostic testing.

Although industrialized Ontario experienced favourable economic conditions during a good part of that time, the present world-wide economic decline is likely to profoundly affect Ontario in the foreseeable future.

The Coalition of Family Physicians of Ontario fully understands the importance of using human health resources in the most effective and cost-efficient manner. However, Bill 179 contains several provisions that are of major concern.

1. The actual increased costs associated with increasing scopes of practice of many providers are not really known. However, what is known is that increasing scopes of practice and the resulting increased access and usage of resources will definitely involve a significant cost. Cost containment was the major reason that physician numbers were sharply curtailed in the past. The previously created shortage of physicians is now leading to expanding the scopes of practice of other health care providers but is likely to increase costs again. The Coalition is concerned that expanding the scopes of other providers is not a solution, but rather a stop-gap measure to address the effects of previous decisions regarding physician numbers, and will bring on further problems of its own. Rather than simply expanding scopes of practice, a much more detailed study of our human health resources is needed before proceeding.
2. Ontario is significantly lagging behind other provinces in the adoption of electronic medical records and health information technology, and only a minority of physicians and other providers have managed to incorporate such technology into their practice. The present Ontario eHealth fiasco will now only further exacerbate this problem. Merely expanding the scopes of practice of other providers to order imaging or laboratory investigations without providing the ability to share these electronically, or in other words to engage in real time collaboration, has the troubling potential to lead to significantly increased duplication of services and thus expenses. Expanding scopes of practice before having

widespread modern information-sharing tools available for providers appears to be like putting the cart before the horse.

3. Expanding the scope of practice of other providers as a response to a physician shortage may be seen by some as necessary at the current time. However, patient safety must always be paramount and mechanisms must first be put in place to evaluate the effects of such a move, in order to ensure that the resulting care is safe, effective and appropriate. Indeed, this is the Coalition's most important concern with the proposed legislation.

Physicians clearly receive the most intensive and lengthy education of any healthcare provider concerning diagnosis and treatment. Is such training really necessary? We believe that it is, and this is underscored by the present trend in family medicine to an even lengthier education as medical knowledge advances. Moreover, seemingly simple things are often not simple. Many examples come to mind. Here are just some of them.

If pharmacists renew an antibiotic, or asthma medication or blood pressure medication, are they trained to evaluate whether the drug is in fact effective and whether it has side effects for the patient involved? Such evaluation is critical, requires a thorough medical knowledge base, and if not performed, can lead to disastrous consequences for the patient. Should we then train pharmacists in diagnosis, record-keeping and treatment? If so, for how long? Should they be allowed to diagnose and treat without such training? Should they be compelled to carry malpractice insurance? In Alberta, where pharmacists can apply for prescribing rights, pharmacists themselves recognize their own limitations, and few have actually applied.

Moreover, physicians are not allowed to dispense the medications that they prescribe, due to an obvious conflict of interest. It puzzles us why this same conflict of interest should now become acceptable for pharmacists and for nurse practitioners. Is it because they, unlike physicians, would ostensibly not be paid an OHIP fee for the prescribing process? If so, then this extension of the scope of their practice might cynically be seen as trying to save costs, but at the expense of patient welfare.

The diagnosis and setting of a broken bone by a nurse practitioner acting independently without physician supervision is another potential pitfall. Orthopaedic surgeons have among the highest rates of malpractice suits, many coming from treatment of fractures, another seemingly simple procedure. Although we acknowledge that remote locations could require a nurse acting relatively independently out of sheer necessity, modern telecommunication with a supervising physician should be used, but as we have pointed out earlier, Ontario suffers from a chronic lack of such information technology.

While Ontario works toward improving access to the healthcare system and patient outcome and satisfaction, patient safety and treatment effectiveness must remain the paramount concerns. There is admittedly much to be done in the realm of collaborative care among different healthcare providers, and the Coalition supports such initiatives. However, we do not support attempts to fill the gaping gaps in physician numbers by turning to providers who may not be qualified for the job. This can only compromise patient safety and outcomes, and increase the costs, thus compromising the sustainability of our medical system. We urge the government of Ontario to slow down and study the issues carefully before launching measures, which may actually make matters worse, just as adopting the Barer-Stoddard report on physician numbers did in the 1990s.

Finally, we also urge the government to consult with physicians, rather than acting unilaterally, even to the point of giving itself the power to take over any regulated healthcare college which does not abide by government policy, as is presently set out in Bill 179. The concept of collaboration cannot be limited to various healthcare professions, but must also extend to government, if it is to have any real meaning. Doing otherwise simply invites further errors, and virtually assures further compromising our already compromised healthcare system.

Thank-you. Questions?

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