Professional standards in the best interest of patients

The article by Dr Prince in the November issue of *Canadian Family Physician*, "Legislating away the future of family practice. Dangerous transition from continuity of care to continuous access,"[1] clearly promotes the perspective of a single physician without verifying its accuracy with medical regulators across the country, or providing medical regulators with an opportunity to respond.

The Federation of Medical Regulatory Authorities of Canada and its member colleges do not support many of the views articulated in Dr Prince's article, particularly those related to the standards and policies we develop and how they are applied in different practice settings.

Medical regulatory authorities have a job to do, and that is to set high standards for professional practice in the best interest of patients. It is the position of the regulatory authorities that physicians have a collective rather than an individual obligation to their patients who must not be "abandoned" after office hours. Physicians and other health care providers must be able to communicate with each other (for example, a pathologist trying to contact a family physician about urgent or critical laboratory results) in a timely and effective manner about the health care needs of a particular patient, especially in urgent situations.

Further, the Federation of Medical Regulatory Authorities of Canada and its members wonder what "peer reviewed" means when linked with this kind of commentary. What is *Canadian Family Physician*'s definition and application of the term *peer review?* Should it not include "source verification" of all the information, for example by contacting the medical regulatory authorities? This likely would have resulted in a more balanced perspective. For example, we noticed that the focus was on Manitoba's Statement 190 that was officially rescinded in December 2015. A call to the College of Physicians and Surgeons of Manitoba would quickly have resulted in up-to-date information about the new direction and the upcoming demonstration project in that jurisdiction.

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Competing interests
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Reference
1. Prince GD. Legislating away the future of family practice. Dangerous transition from continuity of care to continuous access. *Can Fam Physician* 2016;62:869-71 (Eng), e642-4 (Fr).

Expanding after-hours access to primary care unlikely to decrease burden on EDs

In the November 2016 issue of *Canadian Family Physician*, Dr Prince discusses the various pitfalls of recent requirements by several provincial medical colleges for family physicians to "ensure that medical care is continuously available to the patient in his or her medical practice."[1]

As Dr Prince explains, there are many laudable reasons for expanding access to primary care, such as improved management of chronic conditions and increased patient satisfaction. However, as alluded to by Dr Prince, the specific strategy of expanding after-hours primary care service availability in an attempt to mitigate "unnecessary" emergency department (ED) visits or "avoidable" hospitalizations, or to improve ED overcrowding, is based more on intuitive appeal than empirical evidence. In fact, multiple studies and expert panels have found that those patients with minor, non-urgent conditions who present to the ED actually have a negligible effect on ED volumes and ED length of stay, and that expansion of after-hours access to primary care does not substantially lower ED volumes.[2-6] Similarly, Canadian data have shown that those who present to the ED, rather than the primary care clinic, with an exacerbation of an ambulatory care–sensitive condition are in fact sicker than the average ED patient, are more likely to require hospitalization, and are thus likely using the ED appropriately.[7] Emergency department overcrowding is in fact primarily due to hospital-wide issues relating to in-patient bed availability and consulting and diagnostic services.[6,8,9] Previous investments in new primary care models aimed at expanding availability of primary care services have shown no effect on ED use.[10] Nevertheless, the myth of the "primary-care-type" or "inappropriate" ED visit as a driver of ED overcrowding continues to persist.

Expanding primary care access is an important step in achieving improved disease prevention and management. However, we must weigh the increased financial and resource costs of providing expanded after-hours