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 For example, we noticed that the focus was on Manitoba's Statement 190 that was officially rescinded in December 2015.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
Dr Ziomek is President of the Federation of Medical Regulatory Authorities of Canada and the Registrar of the College of Physicians and Surgeons of Manitoba.

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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

care against the demonstrated minimal gains of "avoidable" ED visits and hospitalizations.

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Competing interests
None declared

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Response

I thank Dr Ziomek for responding on behalf of medical regulators to this opinion piece that was published in the November issue of *Canadian Family Physician*.[1] It was good of Dr Ziomek, the President of the Federation of Medical Regulatory Authorities of Canada and the Registrar of the College of Physicians and Surgeons of Manitoba (CPSM), to both challenge the accuracy of the article and to confirm it in the same letter.[2]

Dr Ziomek rightly points out that this is the voice of a single physician, and I am glad that, despite the expanding powers of the professional colleges, a single physician can still express an opinion. However, as Registrar of the CPSM, and with the process around Statement 190,[3] she cannot pretend this represents a unique opinion. Her counterpart from the College of Physicians and Surgeons of Alberta could validate similar concerns in that province.

Despite rhetoric to the contrary, her letter confirms that the CPSM did indeed pass Statement 190 requiring coverage 24 hours a day, 7 days a week, because the After Hours and Vacation Coverage Policy was subsequently rescinded (more accurately not adopted into the new Regulated Health Professions Act). This was in large part owing to pressure from concerned physician groups (Physicians for the Future and others). The fact that the CPSM, in conjunction with Doctors Manitoba and others, is now looking at a "demonstration project"[2] with (hopefully) a more rational assignment of physician responsibility to after-hours access for patients, is exactly the point of my commentary.[1]

As for the position of regulatory authorities on physicians having a "collective rather than an individual obligation,"[2] I think most would agree that physicians must cooperate and work within the system. Unfortunately, the policies referred to in my commentary[1] are applied to individual physicians, and the language is very singular. Indeed, except where formal groups fall under the purview of professional colleges, these policies cannot be enforced on anything but an individual basis. Because the practical application of the policy is unattainable by some individuals, the policy by its very nature is improper. A solo rural doctor or regional specialist, for example, has no collective to call upon. No exceptions are noted in any of the policies, so these physicians have no ability to comply, save to be perpetually available. The policy also effectively outlaws part-time or solo physicians, a view that I do not believe the profession as a whole espouses.

It is interesting that the Federation of Medical Regulatory Authorities of Canada and its college members have identified patients as being "abandoned" after hours.[2] This implies that there was an agreement between the patient and the physician that such after-hours services would be available. I do not believe that most patients have an expectation that they should be able to telephone their dermatologist, surgeon, or even family doctor, any time day or night; nor do I believe that most physicians have ever implied such service. It also suggests that there is no other recourse for care. It is, of course, critical that the health system can deal with emergencies at any hour, but that need not involve the primary physician. Indeed, Dr Salehi's response to my article[4] highlights multiple studies demonstrating that such an approach is neither superior, nor does it achieve the desired system savings.

Dr Ziomek's comments inadvertently highlight what many physicians consider the drifting vision of our professional colleges. There is a feeling that the priorities of these colleges have become inverted. We, as self-regulating professionals, have the privilege of funding a professional college. The primary responsibility of our colleges is to "provide direction to and regulate the practice of the … profession" and "establish, maintain and enforce a code of ethics."[5] As physicians, we define our profession, defend our scope of practice, and describe our "reserved acts" (things we can do that others cannot)[6] through our professional colleges. Clearly the public must be protected within those definitions, but many physicians feel the professional colleges have become more interested in appeasing the public, even at the risk of compromising the integrity of the profession.