Appalling lack of response for referrals

Thank you to Dr Neimanis et al[1] for their article on referrals and wait times. I was appalled by the statistic that 36.4% of requests for consultation did not even receive a response.

I am Medical Director for a hospice and community palliative care outreach program. We receive well more than 100 referrals every month. It is not uncommon to receive 10 or more in a single day. These referrals come from FPs, nurse practitioners (NPs), and specialists like oncologists, respirologists, and cardiologists, just to name a few. We follow the September 2019 "Transitions in Care" policy from the College of Physicians and Surgeons of Ontario:

> 17. Consultant physicians **must** acknowledge referrals in a timely manner, urgently if necessary, but no later than 14 days from the date of receipt.
>
> 18. When acknowledging the referral, consultant physicians **must** indicate to the referring health-care provider whether or not they are able to accept the referral.
>
> a. If they are, consultant physicians must provide an anticipated wait time or an appointment date and time to the referring health-care provider. When providing an anticipated wait time, consultant physicians **must** follow-up once an appointment has been set.
>
> b. If they are not, consultant physicians **must** communicate their reasons for declining the referral to the referring health-care provider.[2]

Most often our response is a consultation letter to the referring physician or NP, as our wait time for new consults is less than 5 days (total days, not business days). We offer same- or next-day consultations when contacted directly by a referring physician or NP. Our wait time is kept low through a combination of real-time triaging and centralized intake that distributes new referrals quickly and appropriately. We follow up with all declined referrals in writing and with a telephone call to the referring provider with a suggestion on how best to redirect their request. As both a focused-practice family physician and a specialist, I would encourage all physicians who receive consultation requests to review their process for receiving referrals and show respect to our colleagues in primary care and, more importantly, patients. While many specialists can and do respond in a timely fashion, my hope is that a one-third nonresponse rate as indicated in this study is an anomaly.

—Darren C. Cargill MD CCFP(PC) FCFP HMDC
Windsor, Ont

Competing interests
None declared

References

1. Neimanis I, Gaebel K, Dickson R, Levy R, Goebel C, Zizzo A. Referral processes and wait times in primary care. *Can Fam Physician* 2017;63:619-24.
2. College of Physicians and Surgeons of Ontario. *Transitions in care*. Toronto, ON: College of Physicians and Surgeons of Ontario; 2019.

Benefiting from privilege

In her thoughtful contribution to the Third Rail column, Dr Dhara admits that she is "a little scared about how people will respond to this essay."[1] As a white, cis-male physician in his 50s, I want to assure Dr Dhara that some of us, at least, are aware of the privilege we might not have asked for, but have benefited from nonetheless. This does not prevent me from recognizing the courage it took for her to "pick up the mic," and I personally am grateful that she remains committed to speaking up and advocating for equity and justice within our profession, which, in the end, will benefit us all. Thank you, and well said!

—Adam Newman MD CCFP FCFP
Kingston, Ont

Competing interests
None declared

Reference

1. Dhara A. Our complicit role in systemic racism. *Can Fam Physician* 2020;66:596-7.

Reflecting on racism in medicine

Thank you so much for this vulnerable article, Dr Dhara.[1] I am grateful you had the courage to write it. We need your voice now more than ever. For context, I am a white, male, family medicine resident in Halifax, NS, with a history of burnout. These past couple of months have been full of self-reflection for me. What I was not yet considering was the largely unacknowledged racism in medicine.

Your article is a great summary of my past subconscious microaggressions. I am listening, learning, and wanting to become a better human being to other human

beings. Your vulnerable and piercing words, crucial to be said and heard today, give me a little more hope for systemic change, as well as more direction for me to enact change. I do hope to run into you someday in Halifax.

—Micah Peters MD
Halifax, NS

Competing interests
None declared

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1. Dhara A. Our complicit role in systemic racism. *Can Fam Physician* 2020;66:596-7.

Hearing an opportunity

Dear Dr Grant[1]:

Yes, I can hear what you are saying. Thank you for saying it so well. As a hearing-impaired physician, my moment of reckoning occurred while working in a rural and remote emergency department as the only physician in the hospital. A few years before this incident, I had realized that I was not hearing well through my stethoscope and switched to an electronic stethoscope that helped immensely. However, one night, a young, soft-spoken, suicidal Indigenous girl came to the emergency department. We sat together in a private examination room to get away from the noise in the department. She sat sideways to me, avoiding eye contact. Her head was down, allowing her long black hair to hide her face. She was sobbing quietly and had difficulty getting her words out. Most of her speech was inaudible. But worse still, I could not see her lips. Until then I had not realized how much I was reliant on lip reading to aid in understanding the sounds that I was gradually not hearing anymore. And compounding the problem was the circumstance of having to ask someone who was so terribly upset and struggling to repeat themselves. It was at that moment that I regretfully decided to retire from emergency medicine.

There comes a point for all of us when we must give up our medical practice. It is painful for those of us who have enjoyed clinical medicine. But it is also dangerous for us to continue on at the expense of our patients. However, this does not have to be the end of our medical careers. There are many other areas of medicine to be explored that can accommodate the hearing impaired. I have a small medical software company. It does not really generate much income, but it does keep me involved medically and serves to help patients. And after all, in retirement, those are worthy goals in themselves.

I hope that you hear me. This could be an opportunity, not a threat. Be optimistic and look for the "possible."

—Murray B. Trusler MD MBA FCFP(LM) FRRMS
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Competing interests
None declared

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1. Grant J. Can you hear what I am saying? *Can Fam Physician* 2020;66:476-7 (Eng), 483-5 (Fr).