ADVOCACY CENTRE
for the ELDERLY

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Sent via email to policyfeedback@cpso.on.ca

Policy Department
College of Physicians and Surgeons of Ontario
80 College Street
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To Whom It May Concern:

RE: Consultation on the College's Draft Policy – *Accepting New Patients*

Thank you for the opportunity to provide input to the College of Physicians and Surgeons of Ontario concerning the consultation on its draft policy entitled *Accepting New Patients.*

The Advocacy Centre for the Elderly (ACE) believes that the first-come, first-served approach is a vast improvement upon the status quo and the College's original draft policy called *Establishing a Physician-Patient Relationship.* However, we still feel there are issues that need to be evaluated by the College before adopting the current draft policy. After providing a brief introduction about the ACE, we will outline our concerns based on our extensive experience advocating for seniors in Ontario.

Introduction to the Advocacy Centre for the Elderly

ACE is a specialty community legal clinic that was established to provide a range of legal services to low income seniors in Ontario. The legal services include individual and group client advice and representation, public legal education, community development, and law reform activities. ACE has been operating since 1984 and it is the first and oldest legal clinic in Canada with a specific mandate and expertise in legal issues of the older population.

ACE receives, on average, over 2,500 client intake inquiries a year. These calls are primarily from the Greater Toronto Area but approximately 20% are from outside this region, and may come from any part of the province, as well as from outside Ontario.

The individual client services are in areas of law that have a particular impact on older adults. These include, but are not limited to: capacity, substitute decision-making and

health care consent; end-of-life care; supportive housing and retirement home tenancies; long-term care homes; patients' rights in hospitals; and elder abuse. In recent years, more than 50% of our clients sought advice on matters relating to health care.

Older Adults and Ageism in Health Care

Ageism is prevalent in Canada. One recent study noted that 84% of Americans and 91% of Canadians reported at least one incident of ageism.[1] Ageism refers to both "a socially constructed way of thinking about older persons based on negative attitudes and stereotypes about aging and a tendency to structure society based on an assumption that everyone is young, thereby failing to respond appropriately to the real needs of older persons."[2] Unlike other stigmatized groups, "social sanctions against expressions of negative attitudes towards the elderly are almost completely nonexistent."[3]

According to the now defunct Law Commission of Canada, "concepts such as age and generations often fail to acknowledge the differences that exist between people within an age group or a generation: this diversity is sometimes more critical than the differences between them."[4] In other words, older adults are not a homogenous group.

Research indicates that not only are Canadians living longer, they are living longer in good health. Although seniors are more likely than younger people to have chronic conditions and to experience poorer health, seniors today are generally healthier than those of previous generations.[5] Unfortunately, many people believe all older adults are sickly and erroneously blame them for increases in the cost of health care. Some physicians are reluctant to accept seniors as new patients on the basis of actual or perceived time demands, and the corresponding fear that they will not be compensated adequately for their time from the Ontario Health Insurance Program. Misperceptions about advanced age, coupled with the physician shortage in Ontario, make it extremely difficult for older adults who do not have a doctor to find one.

It has also been suggested that such stereotypes support policies to reduce social programs for care. These negative assumptions may send the message that older adults are not entitled to services and discourages them from seeking assistance.[6]

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[1] Sean Horton, J. Baker and J.M. Deakin, "Stereotypes of Aging: Their Effects on the Health of Seniors in North American Society" (2007) 33:12 Educational Gerontology at 1021 at 1023.
[2] Ontario Human Rights Commission, *Fact Sheet: Ageism and Age Discrimination*, online: <http://www.ohrc.on.ca/en/resources/factsheets/ageismandagediscrimination>.
[3] *Supra* note 1 at 1023.
[4] Law Commission of Canada, *Does Age Matter?: Laws and Relationships Between Generations* (Toronto: 2004) at 8.
[5] Canada, Special Senate Committee on Aging, *Embracing the Challenge of Aging, Second Interim Report: Issues and Options for an Aging Population* by The Honourable Sharon Carstairs and The Honourable Wilbert Joseph Keon (Ottawa: March 2008) at 47
[6] See, for example, Jane Aronson and Sheila H. Neysmith, "Manufacturing social exclusion in the home care market" (2001) 27:2 Canadian Public Policy 151.

First-Come, First Served Approach

Although the concept of first-come, first served may appear to be self-explanatory, ACE believes it would be useful for the College to provide details as to how it envisions such a system should work in practice for the purposes of clarity and consistency.

Under the current system (which will remain unchanged if the draft policy is implemented), the College recommends five courses of action for potential patients trying to find a new family doctor. The first suggestion is to use the College's on-line doctor search service. As it is only updated quarterly, patients do not find out until they call the physician's office that the information is out of date and the doctor is no longer accepting new patients. The second option is to ask friends and family if their physician is willing to accept them on as a patient. Accordingly, patients must either rely on their friends and families to make enquiries on their behalf and/or they must contact each doctor and request acceptance based on their relationship with a current patient. The third alternative is to contact the local hospital as they might be aware of staff physicians or physicians with hospital privileges who are presently accepting new patients. The fourth option is to query community health centres about the availability of any doctors who are taking new patients. The College's fifth suggestion is to read the local newspapers to see if any doctors are advertising for new patients.

This is a cumbersome process as it is often necessary for patients to make numerous phone calls to many physicians to determine if they are accepting new patients and if not, to request that their name be placed on a waiting list. These waiting lists are maintained by individual physicians and are not subject to public scrutiny. ACE is concerned that waiting lists can be misused by doctors who want to "cherry-pick" only the healthiest patients by either refusing to add those patients who are perceived to be unhealthy to their lists or skipping over those names once an opening is available within their medical practice.

In an effort to fairly allow patients find a family doctor, ACE recommends that the College, in cooperation with the Ministry of Health and Long-Term Care and other relevant stakeholders, consider creating a centralized provincial waiting list, similar to the waiting list for long-term care homes which is administered by the Community Care Access Centres. Under such a system, patients would contact a single agency which would coordinate referrals and ensure the integrity of the list. Not only would there be increased efficiency and transparency but fewer instances of discrimination, as physicians would not be able to refuse a new patient unless there was a satisfactory reason for doing so.

Discrimination

One of the paramount reasons for developing a new policy regarding the acceptance of new patients is to prevent actual discrimination and to alleviate the concerns of the public about perceived discrimination. However, in ACE's opinion, this is not apparent from reading the draft policy due to the minimal discussion (approximately 15 lines) about

discrimination. The language employed by the College also fails to strongly signal that it does not and will not condone discriminatory behaviour by physicians.

The policy also omits any mention that the physician's duty not to discriminate includes a duty to accommodate to the point of undue hardship.[7] The draft policy does not make reference to a directly relevant policy of the College called *Physicians and the Ontario Human Rights Code.* Further, the non-discrimination principle of the Canadian Medical Association's *Code of Ethics* is merely contained in a footnote to this section.

Therefore, in order to emphasize to doctors the seriousness of their human rights obligations (both legal and ethical), ACE suggests that the section in the draft policy dealing with discrimination be amended to: include stronger language condemning discrimination; add information about the duty to accommodate; encourage physicians to read the *Physicians and the Ontario Human Rights Code* policy; and reproduce section 17 of the *Code of Ethics* in its entirety within the body of the final policy.

Line 40 refers to the "Ontario Human Rights Commission." This should be changed to say the "Human Rights Tribunal of Ontario" as this is the body that resolves applications brought under the *Human Rights Code*.

Clinical Competence and Scope of Practice

According to the draft policy, "clinical competence and scope of practice are permissible grounds for limiting patient entry into a practice." If these aspects of the policy are not refined, ACE believes they are likely to be misused in a discriminatory fashion.

It goes without saying that ACE does not want physicians to provide care to patients where he or she does not have the requisite knowledge or expertise. Nevertheless, a physician should not be allowed to seek refuge under the cloak of clinical competence as an excuse not to treat, for example, an elderly person because the physician presumes the older adult will consume too much of his or her time. ACE agrees with the Ontario Human Rights Commission submission respecting the College's earlier *Establishing a Physician-Patient Relationship* draft policy (but which is still applicable to the current draft policy) that: "there must be an actual, demonstrable link between the health service request or care needs being presented to the physician, and any denial of service based on 'clinical competence,' and this should take into account the ability of the [family] physician to provide referrals to specialists where required."[8]

ACE supports those physicians who develop a medical expertise or focus on a particular subset of the population, such as geriatric patients. However, it is our submission that the

[7] *Human Rights Code*, R.S.O. 1990, C. H.19, section 11(2).
[8] Ontario Human Rights Commission, *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario regarding the draft policies relating to establishing and ending physician-patient relationships* (February 14, 2008), online: <http://www.ohrc.on.ca/en/resources/submissions/surgeons>.

vague definition of scope of practice as contained in the *Changing Scope of Practice* policy makes it easy for doctors to use it as a guise for discrimination.

ACE endorses the Commission's comments that a policy should distinguish between "focus" and "medical specialization," as well as requiring family doctors to justify the rationale for their focus and to clearly communicate their focus to potential patients. ACE agrees with the Commission that "if a focus of the practice does not itself attempt to ameliorate conditions of a group identified on the basis of a *Code* ground, it will not be an acceptable one for the purposes of patient selection."[9]

Besides the inclusion of comprehensive definitions for both clinical competence and scope of practice, ACE is of the opinion that it would be helpful for both physicians and the public if the College incorporated further examples into the policy to clarify these concepts.

Conclusion

Generally speaking, the draft policy sets out a positive framework for a doctor's acceptance of new patients. In order to be effective, however, the underlying tone of the policy needs to be strengthened by explicitly denouncing discrimination and refining the definitions for key terminology.

Thank you again for the opportunity to participate in this review. We urge the College of Physicians and Surgeons of Ontario to use our comments, as well as those found in submissions from other stakeholders, to permit individuals to be able to receive equitable access to physicians and health care.

Yours truly,

ADVOCACY CENTRE FOR THE ELDERLY

Lisa Romano
Staff Lawyer

[9] *Ibid.*