Family Medicine in the 21st Century: A Prescription for Excellent Healthcare

By visiting our web site, all references labeled with [hot link] provide recent survey results or a position paper on the reference topics. All papers and surveys developed recently are posted on the website.

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FOREWORD

Family Medicine, the cornerstone of Ontario’s healthcare system, is in crisis. There are insufficient Family Physicians to adequately provide the high quality comprehensive care which the people of this province deserve. A recent survey reveals the depth of public concern regarding this issue. While policy makers debate whether the crisis is due to a supply or a distribution problem, the people of Ontario strongly believe that there is a shortage of Family Physicians and are concerned about the actions to date to address the shortage. The shortage of Family Physicians delivering comprehensive care and the problems facing them in practicing to the full extent of their training and capabilities are described in detail in four Ontario College of Family Physicians (OCFP) papers entitled Where Have Our Family Doctors Gone?

In June of 1999, the OCFP released the initial draft of this document (see Appendix 1) which presented specific recommendations for restructuring the delivery of care by Family Physicians in Ontario. An important goal of the paper was to stimulate dialogue amongst healthcare professionals, the public and the government regarding the function of Family Doctors in the 21st Century, the nature of the infrastructure required to support the practice of Family Medicine and its role in an integrated healthcare system.

The goal of generating dialogue has been met. Members of the public are overwhelmingly supportive of Family Physicians. Their concerns underline the need to modernize the system to ensure that the patient-centred care Family Doctors have traditionally delivered is there when needed. The public recognize that physicians require the help of inter-professional teams to offer comprehensive care and need access to better health information. Physicians provided input as individuals, as members of focus groups and through surveys. Most expressed frustration with the current situation. A strong majority supported the recommendations of Family Medicine in the 21st Century in principle and some raised concerns regarding specific points and suggested ways to address them. At the governmental level, the Minister of Health & Long-Term Care, Ms. Elizabeth Witmer appointed Dr. Robert McKendry as Health Commissioner to lead a fact-finding review concentrating on the supply and distribution of physicians in the province.

In September of 1999, the proposals promulgated in Family Medicine in the 21st Century were the subject of a special meeting – the Family Medicine Forum – hosted by the OCFP Board. In addition to the Board members, representatives from the following healthcare organizations were in attendance: the Ontario Ministry of Health, the Health Services Restructuring Commission, the Ontario Medical Association, the Coalition of Family Physicians, the Professional Association of Internes and Residents of Ontario, the Ontario Hospital Association, the Registered Nurses Association of Ontario, among others (see Appendix 2). As Dr. Duncan Sinclair, Chair of the Health Services Restructuring Commission (HSRC) noted, the forum was the first time that the key players in “primary care reform” had been assembled together in the same room. Dialogue was lively and conflicting visions were more often an issue of semantics rather than irreconcilable concepts. It was apparent that the participants were committed to working together to further enhance patient care in this province. As a result of the meeting, the OCFP undertook
to clarify the language of the proposals and to continue building bridges amongst the key stakeholders.

This version of *Family Medicine in the 21st Century* has been revised to reflect the critical importance of the patient-physician relationship. The pivotal role of Family Physicians in providing and coordinating healthcare at all levels of the healthcare system is emphasized. Continuity of care, an essential component of quality healthcare, can only be achieved in the context of a system that supports Family Medicine through an efficient and economical infrastructure. The integrated healthcare system outlined in this paper is not dependent upon structural changes. Integration requires Family Doctors to play a key role in the care of their patients at all levels of the healthcare system – offices, emergency rooms, hospitals (including care for patients who require specialists), long-term care facilities and home care or community services. The proposed infrastructure includes community-based group practices or practice networks composed of Family Physicians and Nurse Practitioners, professional practice support, and a comprehensive community-wide electronic health information system.

**“Family Medicine – the Heart of the Integrated Healthcare System”**

1. Family Physicians and Nurse Practitioners supporting the patient-physician relationship through a collaborative practice model to deliver the PCCCAR services
2. A Professional Practice Support Team consisting of Nurse Telephone Triage Response System, Urgent Care Nurses, Care Coordinators, Social Workers/Psychologists, Pharmacists, Occupational Therapists and Physiotherapists, Office Nurses and Staff supporting the group practice
3. Consultants, Public Health Departments, Community Access Centres (long-term care facilities and home care services) and Hospitals providing easy access to primary, secondary and tertiary services to assist the individual physicians, group practices and practice support teams in delivery coordinated care for patients

For purposes of clarity the term “Family Medicine,” as used in the document, is defined as follows:

“Family Medicine in Ontario is the provision of integrated and accessible healthcare services by Family Physicians who are accountable for addressing the majority of their patients personal health and healthcare needs through the development of a sustained partnership with patients resulting in continuity of care and positive health outcomes. The focus of Family Medicine, practiced within the context of family and community, is on health promotion, disease prevention, community outreach and public education, illness and curative
services, and rehabilitative and support services.” Family Medicine is supported by a Family Healthcare Infrastructure. (see Appendix 3)

This revised document is not the final set of recommendations. It is intended as a further step in the debate about the restructuring of the delivery of Family Medicine care. Further revisions may be necessary in light of three new projects already being undertaken by the OCFP – developing with nursing colleagues and other healthcare professionals, a collaborative practice model for Ontario; developing a system for accountability, performance measurement and quality improvement for Family Medicine; and outlining for government consideration, an implementation strategy for these proposals.
EXECUTIVE SUMMARY

In Ontario, healthcare reform has focused on institutional changes with little consideration for how such changes would affect the care patients receive from Family Physicians. The impact of these changes on Family Medicine has been onerous. Ontario now has too few Family Doctors for its population (85 per 100,000 compared with a Canada-wide average of 94 per 100,000). As a result, most practicing physicians are overworked and have responded in a variety of ways. In some underserviced regions, physicians have closed their practices and moved to larger centres or out-of-province; thus aggravating an already desperate situation induced by the maldistribution of physicians and public policy decisions.

Other physicians have responded by closing their practices to new patients or by limiting the types of services they offer: no more delivering of babies or emergency room shifts; no more caring for patients in hospitals or providing after-hours and weekend calls; no more home or nursing home visits; rather, a practice now limited solely to walk-in-clinics, office-based practices or locums. Thousands of Ontario residents are not receiving the comprehensive Family Medicine care they deserve and they want action.

My doctor left town. Can you help me to find one? (Caller #3271 M-99) ❖ 5 ~ 6 calls everyday. When will it stop? — Staff, OCFP

My doctor is wonderful. She delivered my first three children. But she told me she stopped delivering babies. I got sent to someone else who is too busy for me. I hope everything goes all right – I am getting up there and you start to worry. — Mrs. J

My mom has had the same doctor for many, many years. I put her in a nursing home – it was an awful thing to have to do. Now I find that her doctor won’t see her there. Some strange doctor that I never met changed all her pills. She is talking nonsense now – I think it’s the pills. The new doctor is never there. What should I do? — Mrs. K

My mom is dying. We’re trying to care for her at home. Our doctor doesn’t make house calls. What are we supposed to do? — Miss K (daughter of a 52-year old palliative care patient)

I’ve got a great doctor, but I was really sick and my daughter called an ambulance. When I got to the hospital they said I had to stay. They told me my doctor couldn’t look after me in hospital. Someone else looked after me. He asked me all these questions. He wanted to know the names of the pills Dr. W told me to take. I don’t know what they’re called – they’re blue and white, and then there’s the yellow one. I don’t think he knew what he was doing. I wish Dr. W had been there. Why don’t they let him come to the hospital anymore? These changes they made to hospitals – I don’t think they are very good. — Mrs. M (82-year old patient)
This paper presents detailed proposals for resolving the current crisis in Family Medicine in Ontario. A sustainable healthcare system is possible only if these recommendations are implemented in their entirety. The key elements of our recommendations are as follows:

1. **Family Medicine as the cornerstone of our healthcare system**
   
The success of the Canadian Healthcare system is largely based on the strength of Canadian Family Medicine\(^5\), \(^6\) which in turn is, in large part, attributable to the superb training that Canadian Family Physicians receive.\(^8\) The four principles of Family Medicine in Canada are: the patient-physician relationship is central; the Family Physician is a skilled clinician; the Family Physician is a resource to a defined practice population; and, Family Medicine is a community-based discipline. Family Doctors are recognized as specialists in comprehensive care. They know their medicine, they are trusted by their patients, they know their patients’ families, and they know their communities. They are ideally placed to manage their patients’ health needs and to advocate for them at all levels of the healthcare system.

2. **All Ontario Residents should choose a Family Physician**
   
The proposals in this document assume that every resident of Ontario will have a Family Physician who will be their point of entry into the healthcare system. Patients will have complete freedom of choice in selecting their Family Physician, but once chosen, a formal registration agreement would cement the relationship. With due notice, patients would be allowed to change physicians; however, it is likely that most would learn to trust their Family Physician and to appreciate the comprehensive services they receive. The odds are that this system would decrease costs due to eradication of duplication of laboratory investigation and “double-doctoring.” The economic case for this proposal is strong.

3. **Family Physicians will offer a defined list of professional services**
   
Family Physicians are committed to offering a wide range of services to their patients. These include health promotion, illness prevention, support for self-care, management of episodic illnesses and injuries, mental healthcare, primary reproductive care, management of chronic illnesses, palliative care and patient advocacy. A complete listing of the services is found in Table 3 in the main body of the text.

4. **Urgent care response will be available 24 hours a day / 7 days a week**
   
In urgent situations, patients must have immediate access to care at any time of the day or night. This report outlines a telephone response and call system that will allow Family Physicians to provide urgent care services through the establishment of an appropriate infrastructure as required.

5. **A new infrastructure for Family Medicine must be established**
   
The Family Healthcare Infrastructure will consists of the following components:

(a) **Group Practices or Practice Networks**
   
Where geographically possible, Family Doctors would form group practices or practice networks of 7 – 16 physicians. The suggested number grouping would ensure that the
group as a whole would have the medical expertise to offer comprehensive medical care to all of their patients. The number would be sufficient to offer 24-hour call for urgent medical situations without being too onerous. Every patient would have his or her own physician, but colleagues within the group with a special interest area such as obstetrics, anaesthesia, emergency care, psychotherapy, palliative care, sports medicine, gerontology, or the care of a diverse multicultural population would be called upon, as necessary. Nurse practitioners would be an integral part of the group and would offer patients the special skills of their discipline.

(b) Professional Practice Support Team

Other healthcare providers such as Registered Nurses, Social Workers/Psychologists, Pharmacists, Occupational and Physiotherapists, and clerical staff would support the group practices or practice networks. Nurses would provide telephone triage to give guidance regarding self-care or to facilitate urgent care by the Family Physician-on-call in the office, emergency room, nursing home or patient’s home in keeping with the requirement of the clinical situation. Assistance in accessing the emergency room would be available, as required.

(c) Community-wide Comprehensive Electronic Health Records

Optimal medical care depends upon ready access to each patient’s health record. This paper proposes the establishment of a comprehensive electronic healthcare record that would, with the permission of the patient, be managed by the patient’s own Family Doctor and be accessible to other members of his or her group. When indicated, the record would be available to consultant specialists, emergency rooms or other medically related personnel or institutions.

(d) Family Medicine would be supported by and formally integrated into all components of the healthcare system

If Family Physicians are to provide continuity of care by coordinating their patients’ care at all levels of the healthcare system, this function has to be formally recognized by all institutions and providers in the system. If this is not done, it may be difficult for Family Doctors to adequately contribute to their patients’ care in specialty units such as intensive care units, surgical units or closed psychiatric wards. Family Medicine will function as the link that enables the healthcare system to be perceived as integrated by the patient.

(e) A Physician Facilitator will assist with the smooth functioning of the Family Healthcare Infrastructure

The Facilitator will help to integrate Family Medicine with institutional and community-based services and with quality and performance reviews.

6. Funding

An increased number of funding options should be made available for Family Doctors. All options should be organized to provide incentives for the delivery of comprehensive care. The paper recommends alternative payment plans such as the blended system outlined in Table 10 in the main text as one of the options to be seriously considered. Special funding will be
required to establish the Family Healthcare Infrastructure including the comprehensive electronic health record.

In summary, the manner in which Family Physicians will offer their patients excellent and comprehensive care in the future is summarized in the following profile of the Family Doctor in the new millennium:

The Profile of the Family Doctor in the 21st Century

- Family Medicine is the **cornerstone** of the integrated healthcare system.
- Family Physicians are the **first contact for medical care** within the healthcare system.
- Family Physicians are recognized as **specialists in comprehensive care** responding to a wide variety of patients’ health concerns and performing many roles ranging from diagnosis and treatment to patient advocacy.
- Family Physicians promote health and provide care to a **defined group of people and their families**, taking into account age, sex and severity of illness of this practice population.
- Patients **choose** their Family Physician and have **access to a comprehensive, defined list of services** with urgent care available twenty-four hours a day, seven days per week.
- Family Physicians practice in **groups** (group practices / practice networks – virtual groups) ideally of 7 to 16 physicians wherever feasible.
- Family Physicians work in a **collaborative practice model** with nurse practitioners, midwives and other healthcare providers.
- Family Physicians use information technology to **manage comprehensive patient records** and to **maintain knowledge of therapeutics to address health problems**. The physician shares patient information to promote best practices respecting the principles of patient confidentiality at all times.
- Family Physicians **coordinate and manage** their patients’ care across the continuum of healthcare services, from promoting healthcare to primary, secondary, tertiary and long-term care.
- Family Physicians **consult with and refer to** specialists with recognized expertise, participating in shared care management and maintaining continuity of relationships with the patients.
- Family Physicians are **affiliated** with one or more hospitals, nursing homes and other community and institutional organizations to facilitate the vertical and horizontal **integration** of the healthcare system’s services to their patients.
a sound economic decision that must go forward — and soon, or we will have lost the system that defines us as Canadians. — Dr. W. Rosser, President, OCFP
1.0 INTRODUCTION: VISIONING THE FUTURE

Canada is internationally admired for having developed an excellent healthcare system that provides its entire population with high quality healthcare at a relatively low cost. At approximately 9% of gross national product, Canada’s healthcare costs are competitive with a number of developed European countries. However, responding to fiscal realities, many provinces have embarked upon healthcare reform. Prior to these reform initiatives, Canadians had consistently reported a high level of satisfaction with the system. The recent negative impacts of healthcare reform have been widely reported in the media and have eroded the confidence of the Canadian public in our system. Canada-wide surveys demonstrate that the public is supportive of efforts to recover previously attained standards and to further enhance access to high quality services.

When healthcare systems in the United States and other countries are compared to Canada’s, it has been shown that the basis for our success is the strength of Canadian Family Medicine. The World Health Organization (WHO) and the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) have recognized the importance of a healthcare system based upon a foundation of Family Medicine. A manual to assist countries to strengthen Family Medicine services has been jointly developed by the two organizations. Yet, in Canada, few of the reform initiatives have been aimed at preserving and enhancing the cornerstone of our healthcare system, Family Medicine. Primary Care Reform is viewed as vital to sustaining access to affordable quality health for future generations of Ontarians. Yet, the main focus of healthcare reform in Ontario has been on the institutional sector. Many of these reform initiatives have had a negative impact upon both patients and Family Physicians; however, the effects have been a “side-effect” of change rather than a planned process of improvements in Family Medicine and in the community-based delivery system. Moreover, the primary care reform pilot project is proceeding slowly and is taking place in isolation of planned changes in other parts of the healthcare system. The project’s focus on physician payment methods and negotiations resulting in physician and patient contracts may have delayed implementation of the project and raised concerns regarding the underlying principles supporting the changes.

Family Physicians recognize the trust that the public places in them and are in a unique position to provide leadership in planning a system that enhances access to affordable, quality healthcare. As the major provider of primary medical care and coordinator of care in all levels of the healthcare system, Family Physicians recognize the public’s need for greater support and assistance and are committed to designing a patient-centred healthcare system that further enhances Family Medicine services. As the voice of Family Medicine in Ontario, the Ontario College of Family Physicians (see Appendix I) has initiated a consultation process among its members, other physicians, nurses, allied healthcare providers and other key stakeholders to develop a vision of Family Medicine as the key to an integrated healthcare system for all Ontarians in the new millennium.
2.0  AN INTEGRATED MODEL OF FAMILY MEDICINE IN THE 21ST CENTURY

2.1  Family Medicine – The Cornerstone of our Healthcare System

Our vision for an integrated model of Family Medicine in the new millennium includes a clear understanding of the vital role played by Family Physicians in our healthcare system. The vision reaffirms Family Medicine as the cornerstone of our healthcare system. The system requires each person to have a Family Doctor that they know and trust, who is supported in the effort to practice in keeping with the Four Principles of Family Medicine (Table 1). By practicing according to the Four Principles, Family Doctors will provide a complete and well-defined basket of services that go well beyond primary care or first point of contact with the healthcare system.

While Family Physicians are the main providers of primary medical services, their scope of practice includes much more than primary healthcare. By recognizing Family Medicine as the cornerstone of our healthcare system, the role of the Family Physician becomes one of helping the patient to navigate an increasingly complex and fragmented healthcare. By enhancing the delivery of Family Medicine, people will be supported in their efforts to maintain optimum health status. By providing an effective infrastructure for Family Medicine, people will have access to comprehensive and timely care for episodic and on-going health problems. By supporting the Family Physicians as the integrator who brings together the component sections of the healthcare system, the patient’s experience will be a positive one with better health outcomes. Collaborating with nursing colleagues and other allied healthcare providers such as pharmacists, social workers, dietitians, physiotherapists, etc., Family Physicians are uniquely trained to provide the broad scope of services that patients need and want; however, they need assistance to do so.

During the past forty years, the Canadian and Provincial Colleges of Family Physicians in conjunction with medical schools across Canada have worked vigorously to improve the knowledge, skills and education of our Family Physicians. All programs in the sixteen medical schools are accredited regularly to ensure quality education for Family Doctors. As a result, our Family Physicians are among the best-trained physicians in the world and are able to provide the broadest scope of medical services seen in any country in the world.8

The prime goal of our Canadian educational programs in Family Medicine is to provide physicians with the knowledge and skills they require to provide the highest quality of healthcare for our citizens.9 To this end, the Four Principles of
Family Medicine were developed by The College of Family Physicians of Canada to provide a framework for the practice of Family Medicine and for the continuing education of Family Physicians (Table 1).
### Table 1: The Four Principles of Family Medicine

<table>
<thead>
<tr>
<th>The patient-physician relationship is central to the role of the Family Physician.</th>
<th>The Family Physician is a skilled clinician.</th>
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<tbody>
<tr>
<td>Family Physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients’ response to sickness. They are aware of their strengths and limitations and recognize when their own personal issues interfere with effective care.</td>
<td>Family Physicians demonstrate competence in the patient-centered clinical method. They integrate a sensitive, skillful and appropriate search for disease. They demonstrate an understanding of patients’ experience of illness (particularly their ideas, feelings, fears and expectations) and the effect of illness on patients’ lives.</td>
</tr>
<tr>
<td>Family Physicians respect the primacy of the person. The patient-physician relationship has the qualities of a covenant — a promise by physicians to be faithful to their commitment to patients’ well being, whether or not patients are able to follow through on their commitments. Family Physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power.</td>
<td>Family Physicians use their understanding of human development and family and other social systems to develop a comprehensive approach for promoting health and managing disease and illness in patients and their families.</td>
</tr>
<tr>
<td>Family Physicians provide continuing care to their patients. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time, the relationship takes on special importance to patients, their families and physicians. As a result, Family Physicians become advocates for their patients.</td>
<td>Family Physicians are also adept at working to reach common ground with patients on the definition of problems, goals of treatment, and the respective roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to take charge of their own healthcare and make decisions in their own best interest.</td>
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<tr>
<td>Family Physicians have an expert knowledge of the wide range of common health problems of patients in the community and of less common, but life-threatening and treatable emergencies in-patients of all ages. Their approach to healthcare is based on the best scientific evidence available.</td>
<td>Family Physicians have an expert knowledge of the wide range of common health problems of patients in the community and of less common, but life-threatening and treatable emergencies in-patients of all ages. Their approach to healthcare is based on the best scientific evidence available.</td>
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</table>

<table>
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<tr>
<th>The Family Physician is a resource to a defined practice population.</th>
<th>Family Medicine is a community-based discipline.</th>
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<tr>
<td>Family Physicians view their practices as “populations at risk” and organize their practice to maintain the health of their patients whether or not they visit the office. Such organization requires the ability to evaluate new information and its relevance to practice, knowledge and skills to assess the effectiveness of care provided by the practice and to make appropriate use of medical records and other information systems to plan and implement policies that will enhance patients’ health.</td>
<td>Family practice is based in the community and is strongly influenced by community factors. As members of their practice communities, Family Physicians are able to respond to people’s changing needs, to adapt quickly to changing circumstances and to mobilize appropriate resources to address patients’ needs.</td>
</tr>
<tr>
<td>Family Physicians have effective strategies for self-directed, lifelong learning.</td>
<td>Clinical problems presenting to a community-based Family Physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family Physicians are skilled in dealing with ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from minor and self-limiting to life threatening) and complex biopsychosocial problems. Family Physicians provide palliative care to people with terminal illnesses.</td>
</tr>
<tr>
<td>Family Physicians have the responsibility to advocate public policy that promotes their patients’ health.</td>
<td>Family Physicians care for patients in offices, hospitals (including emergency departments), other healthcare facilities and patients’ homes. Family Physicians see themselves as part of a community network of healthcare providers and are skilled at collaborating as team members or team leaders. They consult with and refer to specialists</td>
</tr>
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</table>
| Family Physicians accept their responsibility in the healthcare system for wise stewardship of scarce resources. They consider the needs of both individuals and the community. | }
2.2 Community-Based Delivery Systems

The healthcare system across Canada is shifting from a hospital-based to a community-based model of care. Table 4 demonstrates that only 1.0% of people require care from a consultant or community hospital and only 0.01% from a tertiary referral centre. Yet, most of our healthcare resources are spent in the hospital sector. As a result, many of the reform initiatives have been aimed at downsizing the hospital sector.

The results of hospital reform have changed the settings in which complex and more intensive care is delivered. Previously, hospitals were able to provide back-up care whenever the community services were overwhelmed. Now, Family Physicians and community-based nurses are providing back-up for a downsized and overwhelmed hospital system. Adequate financial and administrative resources to meet the public’s needs have not been forthcoming and this must change. Resources need to be added outside of hospital settings to the community-based delivery system to provide affordable, quality care close to home. Resource reallocations should include funding for evidence-based health promotion and patient education. Family Physicians and other healthcare professionals need to work together to emphasize healthy lifestyles to ensure that people maintain health. As demonstrated in Table 4, 25% of people remain well in any given month and 50% do not seek care. The key to a sustainable healthcare system in the future is health maintenance and ensuring that people are well skilled in self care. Patients cannot be held accountable to use our health system wisely without the knowledge and skills acquired through health promotion and patient education programs. Patient education is, therefore, a key component of the Family Healthcare System of the future.

Table 2: Describing Illness in the Community: Illness for 1000 Persons during a one month period

<table>
<thead>
<tr>
<th>Illness</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>0.01% receive care in a tertiary care hospital</td>
<td>0.01%</td>
</tr>
<tr>
<td>1% receive care in a community hospital or by a consultant</td>
<td>1%</td>
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<tr>
<td>24% receive primary medical care</td>
<td></td>
</tr>
<tr>
<td>50% experience some form of illness but do not seek medical care</td>
<td></td>
</tr>
<tr>
<td>25% of people experience no illness</td>
<td></td>
</tr>
<tr>
<td>Family Physicians provide or coordinate hospital and consultant care</td>
<td></td>
</tr>
<tr>
<td>Family Physicians provide primary medical care and coordinate community and long-term care</td>
<td></td>
</tr>
<tr>
<td>Family Physicians &amp; nurses encourage and provide patient education to support self care</td>
<td></td>
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<tr>
<td>Family Physicians and nurses promote healthy lifestyle addressing determinants</td>
<td></td>
</tr>
</tbody>
</table>
1% of the care is delivered in hospital!!! Then how come 90% of the money in our community goes there. Care has shifted to the community. Who delivers community-based medical care? We do but we don’t have the resources to do the job properly.

— Dr. R

2.3 Removing Barriers to Care

Given the cultural and geographical diversity in Ontario, special arrangements are needed to ensure that Family Medicine services address the specific needs associated with each particular community. Access to comprehensive services should take into account marginalized populations such as the homeless, mentally ill, cognitively impaired, refugees and aboriginal populations. These populations may be best served by Family Physicians who have developed expertise, ongoing support and involvement with these communities and who are able to address the linguistic and cultural needs of patients. Community health centres with multi-disciplinary teams working together to provide care for marginalized populations can also be effective in serving special needs groups. The Ontario College is working with the Association of Community Health Centres in this regard.

The Family Healthcare Infrastructure must be locally adapted to address the needs of populations residing in rural, suburban, urban and inner city locales. There are no “cookie cutter” solutions for Ontario, and only those that take into account the province’s diversity should be applied.

My mom had a stroke. She used to speak a little English. She lost it. Now, no one understands her. I can’t be there all the time. Why don’t they have doctors and nurses who can speak our language? — Mrs. T

There are as many people in Toronto that are “underserviced” as in the rest of the province. Toronto’s just a bunch of towns and cities that grew together. Some of them don’t have enough doctors. What’s different is that whole populations are underserviced. There are major cultural and linguistic barriers to care. The care for the homeless and psychiatric patients and teens is abysmal. If the doctors in Toronto were redistributed better, it would help, but there would still be barriers to care for those hard to serve populations. — Dr. R

It costs so much more per person to deliver care in Toronto. This is where poverty, homelessness and ethnic differences really impact on the cost of care. Population based funding formulae that address only age and sex will do us in. We’ll never be able to meet the unique needs of our various populations. — Dr. R (Toronto)
2.4 Patient Choice

Every person in the province deserves to have a Family Physician that they know and trust. The term “rostering” refers to a system that restricts patients from seeing another physician without a referral. The effort to cut-down on “double doctoring” and duplication of diagnostic and treatment efforts is needed; however, the rostering system has come to be associated with a movement to change the way physicians are funded into a “capped” system that penalizes the doctor for the public’s perceived misuse of the system. Physicians view negation of their income for patient behaviours in an unfavourable light. The public is confused by the term Primary Care and confuses the reform initiatives with a movement towards a USA HMO/managed care system that will restrict their access to necessary care. Signed contracts result in increased concern amongst physicians and patients alike in this regard. It should be noted that managed care is rapidly falling out of favour in the United States due to patient concerns and liability issues.

Patient Choice of Family Physician is, therefore, the preferred option. The Patient Choice system would provide patients with easy access to comprehensive care so that they would stay within the Family Healthcare system. By sharing information electronically between providers, Family Physicians would access the information needed to address the underlying reason for patients seeking care elsewhere. Building a system based on trust and respect between the patient and the physician is the preferred option.

Forcing people to use one doctor will not work. It violates the Canada Health Act. Build the system properly – like in your paper – and they will come. — Dr. D

We propose that the patient signs a release of information agreement allowing their Family Physician to collect, collate and access all their personal health information. The agreement would specify other healthcare providers who could access the information and what level of permission from the patient would be required. Each individual would only have one such agreement in place with a single physician, but the individual would have the right to change physicians 4 or 5 times in any given year. Special agreements would be made for commuters and individuals with summer cottages and other second homes to ensure that care and
information-sharing occurred between providers in these settings and the Family Doctor.

The Patient Choice system will strengthen the patient-physician relationship that is at the heart of Family Medicine by providing physicians with an accurate list of the patients they serve and by clearly identifying their accountabilities to those patients. Registration with an organization is seen to dilute the lines of accountability and fragment care. Patients must be registered with an individual family physician to cement the patient-physician relationships in the accountability model we propose.

The bean counters want me to call my patients “customers” as if they come to me to buy bread and milk. Have they never heard of the Hippocratic oath? Don't they understand the sacred covenant that is encapsulated in the “patient-physician relationship” – the obligations, responsibilities and accountabilities that I feel to my patient? Why do they keep throwing the baby out with the bathwater? It is time to preserve, not change, what is working in our system. — Dr. J

2.5 The Scope of Services

Every person in the province deserves to have a Family Physician that they know and trust. As the Profile of the Family Doctor in the 21st Century points out, each physician should provide his or her patients with access to a broad, well-defined range of services. We believe that the scope of core services patients should expect from their Family Doctor is as follows:

Table 3: Services to be Provided by Each Family Physician (PCCCAR Report 1996)¹⁰

<table>
<thead>
<tr>
<th>Principle I: The Physician-Patient Relationship is Essential</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advocacy for the patient in the system</td>
</tr>
<tr>
<td>• Primary mental healthcare including psychosocial counseling</td>
</tr>
<tr>
<td>• Support for those terminally ill</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle II: The Family Physician is a Competent Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appropriate interventions for episodic illness and injury</td>
</tr>
<tr>
<td>• Primary reproductive care</td>
</tr>
<tr>
<td>• Diagnosis and initial and ongoing treatment of chronic illnesses</td>
</tr>
<tr>
<td>• Care of the majority of illnesses (in conjunction with consultants, if required)</td>
</tr>
<tr>
<td>• Supportive care in hospital, in home and in community care facilities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle III: The Family Physician is a Resource to the Practice Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health assessments</td>
</tr>
<tr>
<td>• Clinical evidence-based health promotion and illness prevention</td>
</tr>
<tr>
<td>• Education and support for self-care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle IV: The Family Physician is Community-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Arrangement for 24-hour 7-day a week response for urgent problems</td>
</tr>
<tr>
<td>• Service coordination and referral</td>
</tr>
<tr>
<td>• Coordination and access to rehabilitation</td>
</tr>
</tbody>
</table>
This list of services was developed by the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) and adapted in keeping with the Four Principles of Family Medicine. This delineation of the scope of services that should be available from Family Physicians has not been formally implemented province-wide; this needs to happen. More than two-thirds of our members felt that the commitment of a Family Doctor to their patient should include the provision of twenty-four hour, seven days per week urgent care services. The provision of the PCCCAR services accompanied by urgent care on an around-the-clock basis by Family Physicians or their colleagues will provide patients with enhanced care in an effective and cost-efficient manner. A coordinated system of this nature is the key to reducing overcrowding in our emergency departments and costly duplication of services.

I asked my doctor why she didn’t come to see me in the hospital. She said she was too busy – didn’t have privileges at the hospital any more and was sorry. I said it was OK – but it wasn’t. I needed her. — Mrs. L

2.6 Urgent Care Response

The need for 24-hour 7-day per week access to Family Physicians is a given; however, the patients of many Family Physicians are not provided with this service. Patients are forced to access walk-in clinics and Emergency Departments for care that could be delivered more economically in Family Practice offices. In the settings that patients are forced to use, lack of access to patient information makes diagnosis and treatment difficult and more expensive. Follow-up and ongoing care is often problematic due to the lack of coordination between these sites and Family Doctors.

I went to the same walk-in clinic with the same problem three times. They told me three different things were wrong – said I need a CT scan. My own doctor knew what was wrong and I was better the next day. — Talk Show Host

The expressed need is obvious, but physicians are justifiably concerned about the added workload implications in light of current conditions.

You can’t get blood out of a stone. I’m working as hard as I can and I can’t do more. People have to realize that doctors are human too. — Dr. K

Telephone triage systems operated by highly skilled nurses would provide patients with guidance and advice regarding self-care and direct callers appropriately to the Family Physician-on-call or to the Emergency Department as appropriate. Feedback from the Primary Care Reform site in Paris, Ontario demonstrates that this type of system is very supportive of their efforts to provide 24/7 care and has reduced a significant component of their workload. The Family Physician-on-call will be further assisted to manage urgent problems by extending office hours during the evening and on weekends to help concentrate patient visits.
system will reduce inappropriate visits to the Emergency Departments, with only serious or life-threatening situations handled by the emergency physicians. While appreciating the cost of a local system, physicians are uncomfortable with a “1-800-call-texas” model. The nurses need to know and understand the local community and be able to support individual patient care. The telephone system would provide a major link between Family Physicians and Emergency Departments.

Why haven't you included Emergency Departments as part of the primary care system connected with the telephone triage and on-call system? — Dr. D (ER Physician)

Each group practice or network will need flexibility to develop a system that provides access to urgent care in the most logical manner and at the most appropriate site. In small communities, combining hospital/emergency responsibilities with group call may make the most sense. What is most important is the maintenance of an effective information system to ensure that the care provider has access to the health record, and that communications occur with the Family Doctor in that he/she can participate in care decisions whenever possible and provide effective follow-up for the patient.

My doctor is great. When she is not on duty, you can go to the after-hour clinic she runs with her partners. Our little guy has been sick so often, I know them all fairly well. What's great is that the next day, Dr. P knows that we ran into trouble and her nurse calls to see if everything is OK. We had a big problem and went to the hospital. Dr. P didn't know anything about it. Why not? — Mrs. T

2.7 An Infrastructure for Family Medicine

Ninety percent (90%) of the people in this province can identify their own Family Physician and rely heavily on that doctor for care. However, our system is such that many Family Physicians work in relative isolation. Provincial governments in Canada have not invested in an infrastructure to support Family Medicine. This must change. The infrastructure needed to support Family Physicians includes group practices or practice networks of physicians working in collaboration with nurse practitioners. The groups should be supported by Family Practice nurses and other healthcare professionals, information technology and telephone triage systems. Physician facilitators are envisioned to assist with the smooth function of the Family Healthcare Infrastructure. Each physician, whether working in a group practice or as part of a practice network, needs office space and staff. As well, the group will need clinic locations to provide access to after-hour urgent care and pre-screening through the nurse telephone triage system.

(a) Group Practices and Practice Networks

In a recent survey to our membership, over ninety-seven percent (97%) agreed that continuity of care by a Family Physician is an essential
component of Family Medicine. This means that the patient receives coordinated care, regardless of the healthcare setting, by someone they know and trust. The OCFP proposes that the PCCCAR core services be made available to all patients including telephone response and urgent care. It is very unlikely that any solo physician or a small group of physicians would be able to meet these requirements; therefore, care would need to be provided through group practices or practice networks.

Really enjoyed your paper *Examples of Excellence in Family Medicine*, you should add my partners and me to your list of groups that are working well together. — Dr. D

Where sufficient numbers permit and where geographically feasible, we propose that Family Physicians work in groups of seven to sixteen physicians with a publicly funded nurse practitioner for every three to four physicians in the group. Experience has demonstrated that groups of fewer than six to seven physicians would have difficulty managing the scope of services; however, special arrangements will need to be made for small, isolated, rural communities. Groups of more than sixteen physicians tend to be bureaucratic, require costly managerial support and are difficult to manage. Group size and the ratio of Family Physicians to nurse practitioners should be left to the group participants to decide, based on community size and organization.

Family Physicians could be organized into formal group practices or as practice networks (virtual groups). In a group practice, physicians would share a single practice location. In a practice network or virtual group, solo practitioners or small group practices of two to three physicians could link together to form a larger group of seven to sixteen physicians. The practice network should provide access for patients to the designated scope of services without physicians necessarily being required to change their practice location. This idea was acceptable to our members.

So I would see my own doctor or one that he likes working with and respects. Sounds good to me. — Talk Show Caller

Within each group practice or practice network, the expertise of each physician could be used to the advantage of all patients who chose physicians within the group. For example, if a particular physician did not provide intrapartum obstetrical care or was not skilled in anaesthesia, psychotherapy, palliative care, etc., a colleague within the group who was interested and skilled in this area of care could provide these services. Guidelines to equitably distribute workload would need to be established among the practice members.

Wouldn't it be great if my doctor's nurse could answer the phone all the time?
Most of the time she can tell me what to do and I don't need to bother the doctor. She knows all the drugs I'm on and what I go through after chemo – she's great! — Cancer Patient

(b) **Enhanced Role of Nurses**

The vital role of nurses is recognized by Family Physicians throughout the province. While Family Healthcare teams should include other healthcare professionals such as dietitians, social workers, psychologists, physiotherapists, pharmacists, etc., it is important that the basic Family Healthcare Infrastructure for Family Medicine includes roles for Nurse Practitioners, Family Practice Nurses and Midwives. The Ontario College of Family Physicians and its members are supportive of an expanded role for nurses that makes maximum use of nurses’ special knowledge and skills. Many of our members have longstanding experience working collaboratively with nurse practitioners and Family Practice nurses.

A collaborative practice model based on a mutually supportive role between doctors and nurses will ensure a comprehensive service for patients. Recognizing the vital role that nurses play in our healthcare system, enhanced nursing roles and responsibilities will lead to further improvements in healthcare in our province. Nursing expertise in dealing with chronic problems such as diabetes, asthma and respiratory diseases have been documented and our members fully support building on that expertise to further strengthen Family Healthcare services. The collaborative practice model is seen as a major step forward in further developing Family Medicine as a specialty in the delivery of comprehensive care.

I want to work with a nurse but who’s liable if something goes wrong when she sees the patient? — Dr. B

What concerns me is the model in which the nurse sees every patient first; deals with the easy stuff and send the difficult patients to me. Sorting patients based on acuity is simply the wrong way to go. It duplicates effort and results in further fragmentation of care. The system should be designed to support continuity of care. Doctors and nurses need to get to the table and figure out what each professional does best rather than planning in isolation. — Chief of Family Practice (partner in a collaborative practice with a nurse practitioner)
Many of our members expressed concern regarding the role of nurses. They emphasized that they want to work in a partnership arrangement with nurses, but are concerned about funding for nurses, and their own personal liability for nurses using a collaborative practice model. Our members are not supportive of an independent free-standing practice model for nurse practitioners or midwives. The role and working relationship between physicians, nurses and other allied healthcare providers needs to be addressed. The OCFP is facilitating an initiative to further define the working relationship within the collaborative practice model. The model will build on the strengths of each profession rather than the “physician replacement” model seen in American primary care models. The model will be developed by a joint OCFP/RNAO Task Force and added as an addendum to this document as soon as it is available.

When you put a nurse and physician together, you don’t get 1 + 1 = 2. You get 3. There is a synergy from sharing knowledge between professionals with different perspectives that makes for better patient care. — Mrs. J, RN–EP

(c) Community-Wide Comprehensive Electronic Health Records

With the patient’s permission, all members of a group who share responsibility for care of a defined practice population with the patient’s Family Physician, would have access to a comprehensive electronic health records system. The management of the complete health record for each person registered with an individual Family Physician would be the responsibility of that doctor. Whenever an individual received care from any other healthcare provider or agency, a record of the provided care would be forwarded to the patient’s designated Family Physician as the coordinator of the patient’s comprehensive electronic health record (CEHR). Information in each health record would include specialist care, hospital care, emergency care, long-term and community-based care. To ensure maintenance of confidentiality of patient records, a Health Information Privacy Commission for Ontario is recommended. While it is important that the CEHR is available between group partners to enhance office-based practice, it is the CEHR’s ability to enable integration of information between all healthcare providers in the broader health system that is the essential component of a system that supports Family Doctors in the delivery of comprehensive services. Others who would be given access to all or part of the record would be specified by the patient.

A patient saw me the other day with a complicated problem. In reviewing her case, I found four different medical records. Of course they weren't connected and all of them partially completed with major inaccuracies. The patient didn't know she had these records. I had to research, on my own time, trying to find out the type of treatment my patient received. — Dr. R
Our members were most concerned about the capital and operating costs of the information technology needed to support a single health record for each patient. They recognize that their limited budgets for office overhead could not support the powerful systems that are needed and expressed concerns about the agreement in the Primary Care reform sites for physicians to assume one third of the IT costs. A sound business case can be made for investing in information management technology at the provincial level and we very much support efforts in this regard. Physician’s access to evidence-based guidelines, protocols, care maps, drug interactions and other educational tools will provide access to health information necessary for sound decision-making and is considered to be an essential component of the system in light of the explosion of health information available and their liabilities if they fail to use that information in patient care.

I know we need IT but I can’t afford it, and no one can decide what we should use. — Dr. W

You may not be able to afford it now but one day the business case will be so strong that you wouldn’t be able to afford not having one. — Dr. M

(d) **Group Facilitators/Quality Improvement**

To assist with the smooth functioning of the practice groups or networks in each community, one of the Family Physicians would be chosen to serve in the role of Facilitator. Key components of the role would be to assist the groups integrate with the broader healthcare system, encourage quality improvements, collaborative relationships and effective resource utilization. Any patient who was not able to find a *physician of choice* would be assisted by the Facilitator.

Facilitators require financial support and a reporting structure. The Ontario College has identified three reporting structures, but other approaches may make sense as well. Family Practice could be viewed as an independent system and the Facilitator would be accountable to Family Physicians in the groups. This model lends itself to support from provincial bodies such as the College of Physicians and Surgeons of Ontario. The Facilitator could be the Chief of Family Medicine in the local hospital and take responsibility for supporting Family Physicians within the hospital and the surrounding community. The Facilitator could also be part of a regional network and report through a regional structure such as a committee of the District Health Council or Ministry of Health Regional Office.

A natural leader will emerge to make it happen. Support that person and the system will be up and running in no time. That is what happened in our town.
(e) **Practice Setting/Group Support**

Physicians and nurses need supportive clinical office settings to provide telephone responses and urgent care on a twenty-four hour a day, seven days per week basis. The settings need easy access to a lab, diagnostic imaging and a pharmacy. In smaller communities, these settings may be provided by the local hospital. In larger communities, publicly-funded support for appropriate settings will be required either directly or through funding models. Clerical and other support is required to ensure the smooth function of the group. Separate funding for infrastructure or funding models such as that provided by blending funding are needed to address overhead costs for Family Physicians.

> I'm seeing a new patient. She had the same doctor for several years but she broke her hip. Now, she can't get up the stairs to see him. Why would any doctor have an office that the elderly can't get to? – Cherry-picking? — Dr. W

### Table 4:

<table>
<thead>
<tr>
<th>Family Medicine supported by the Family Healthcare Infrastructure Components</th>
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</thead>
<tbody>
<tr>
<td><strong>Practice Network A</strong></td>
</tr>
<tr>
<td>Solo Physicians (7 – 16)</td>
</tr>
<tr>
<td>Nurses Practitioners (2 – 4)</td>
</tr>
<tr>
<td><strong>Group Practice B</strong></td>
</tr>
<tr>
<td>Family Physicians (7 – 16)</td>
</tr>
<tr>
<td>Nurses Practitioners (2 – 4)</td>
</tr>
<tr>
<td><strong>Practice Network C</strong></td>
</tr>
<tr>
<td>Solo Physicians &amp; Small Groups (7 – 16)</td>
</tr>
<tr>
<td>Nurse Practitioners (2 – 4)</td>
</tr>
</tbody>
</table>

• Healthcare Professional Support Team
• Information Technology
• Nurse Telephone Triage System
• Office/Clinic Setting

Family doctors require a supportive infrastructure to provide the PCCCAR Services. It cannot be done in isolation. — Dr. H

Emergency physicians, surgeons and cardiologists don't pay for the infrastructure. — Emergency
Rooms, ORs and ICUs) needed to support them. Family Doctors are the only ones required to pay for their own infrastructure – or do without. — Dr. T

2.8 Coordination of Care Through the Continuum of Services

This model recognizes the key role of Family Physicians and their accountability for patient outcomes. A Family Healthcare Infrastructure will improve access to quality healthcare services, reduce the cost of service duplication and of care delivered in inappropriate settings. Access to specialists, hospitals, long-term care institutions, home care and public health services should be coordinated by the Family Physician or practice partners. As a result of the downsizing of hospitals and transfer of care to other components of the system, these services must be provided within the terms of the Canada Health Act.

To facilitate the coordination of patients through the continuum of service delivery, it is proposed that hospitals, Community Care Access Centres, public health and other community-based organizations develop easily accessible systems that support the role of Family Physicians as coordinators of care. Integration of the Family Medicine with other healthcare organizations is vital if fragmentation of care is to be reduced and the therapeutic relationship between doctor and patient is to be enhanced. As demonstrated in Table 5, the current system lacks both patient and provider accountability and fragmentation makes it difficult to maintain the patient-physician relationship.

Table 5: Part 1 – Current Fragmented System

<table>
<thead>
<tr>
<th>Accountability</th>
<th>Provision of Care</th>
<th>Maintenance of Patient-Physician Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Physician</td>
<td>Family Practice Visit</td>
<td>• FP-patient relationship is maintained and enhanced</td>
</tr>
<tr>
<td>Specialist</td>
<td>Specialist Visit</td>
<td>• FP coordinates access to specialist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• FP-patient relationship may be splintered if patient continues primary care relationship with specialist; relationship with specialist is usually for one condition/health problem only</td>
</tr>
<tr>
<td>On-Call MD</td>
<td>Walk-in Clinic</td>
<td>• FP-patient relationship is splintered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient develops limited relationship with different physician each visit</td>
</tr>
<tr>
<td>Community Care Access Coordinator</td>
<td>Home Care/Community</td>
<td>• FP-patient relationship usually maintained but approach to care between FP and providers may not be coordinated effectively</td>
</tr>
<tr>
<td></td>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>Most Responsible Physician</td>
<td>Hospital</td>
<td>• FP may coordinate access to hospitalization and be the MRP; otherwise, FP-patient relationship may be splintered in favor of specialist-patient relationship; specialist may differ for each hospitalization</td>
</tr>
<tr>
<td>Institution’s MD</td>
<td>Long-Term Care Institution</td>
<td>• FP-patient relationship may be splintered and approach to care between FP and providers may not</td>
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</table>
Each organization needs to support systems that facilitate the coordination of care by Family Physicians. In turn, the Family Physician needs to provide and coordinate care for his or her patients throughout the continuum of service delivery including hospital-based care. This means that Family Physicians would need to be an active or associate member of the medical staff of their local hospital.

The doctors are threatening to pull out of the on-call roster. Let them. I’ll hire a general internist to look after our orphaned patients — Hospital CEO

So far we have been able to find someone to look after our “orphaned” patients while in hospital. It’s trying to find someone to take care of them after they leave – that’s the problem. — VP Nursing

Table 5, Part 2 demonstrates the advantages of the OCFP’s *Integrated Family Medicine System* over the current fragmented system with regard to increased patient and physician accountability, and the maintenance of the therapeutic relationship between patients and Family Physicians.

<table>
<thead>
<tr>
<th>Family Physician Accountability</th>
<th>Family Healthcare System</th>
<th>Maintenance of Patient-Physician Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice Visit</td>
<td>FP-patient relationship maintained and care may be enhanced through FP/RN team approach to care delivery</td>
<td></td>
</tr>
<tr>
<td>FP Group or Practice Network or CHC</td>
<td>FP or FP/RN team supported by a group or practice network to provide access to the full continuum of Family Medicine services and urgent care on a 24-hour/7-day per week basis. FP-patient relationship maintained.</td>
<td></td>
</tr>
<tr>
<td><strong>Integrated Delivery Service</strong></td>
<td><strong>Maintenance of Therapeutic Relationship</strong></td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td>FP coordinates access to consultants and maintains records with the relationship being consultant to the FP/patient. FP-patient relationship maintained. Shared care model used.</td>
<td></td>
</tr>
<tr>
<td>Emergency Department</td>
<td>FP or FP group/network coordinates access to emergency care for urgent/emergent problems. FP-patient relationship maintained.</td>
<td></td>
</tr>
<tr>
<td>Home Care/ Community Services</td>
<td>FP or FP/RN team works closely with home care/community services to coordinate care.</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>FP or FP/RN team works closely with hospital-based consultant and RN to coordinate inpatient care and develop discharge plan.</td>
<td></td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>FP or FP/RN team works closely with LTC staff to coordinate care.</td>
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The Ontario College of Family Physicians has developed a paper entitled “Centres of Excellence in Family Medicine”. The paper documents a number of models of integration proposed or established in Ontario in which Family Physicians working together in group practices or practice networks are linked to specialists, hospitals, long-term care, Community Care Access Centres, public health and rehabilitation services. In all of these models, the role of the Family Physician is key to the success of the fully integrated system.

Family Physicians recognize the vital and important role of our specialist colleagues and their efforts to provide better coordination and communication between Family Physicians and themselves. Several specialties have developed “shared care” delivery models in which the specialist provides guidance and support for Family Physicians to facilitate in the joint care of the patients. This model proposes increased communication between Family Physicians and specialists to better meet the needs of patients requiring specialized care. The model also ensures that Family Physicians are equipped to provide the ongoing care required by the patients. The “Shared Care” System for mental health in Hamilton is a good example of the model.

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Shared Care – works great! The psychiatrist meets with the patient and me, and together we plan the care. I monitor the patient and if there are any problems, the consultant is only a phone call away. — Dr. B

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2.9 Integration of the Healthcare System

An enhanced role for Family Physicians and nurses through the continuum of care will be a major step forward in providing access to better coordinated patient care. Integration of Family Medicine with other components of the healthcare system is vital to the sustainability of quality healthcare in Ontario. Across Canada, there are several examples of regional governance models to integrate healthcare organizations but physicians have generally been excluded from these healthcare reform initiatives. Family Medicine must be integrated with each component in the healthcare system if we wish to attain a truly integrated system that provides access to affordable, high quality, coordinated care.

To facilitate the integration of Family Medicine within the overall healthcare system, three levels of integration are envisioned. Individual Family Physicians and their colleagues would continue to develop collaborative relations within their group practice or practice network and with local organizations such as hospitals, Community Care Access Centres, public health, etc. A Physician Facilitator would assist several real or virtual groups to more fully integrate Family Medicine with other services offered in the community. A similar role is envisioned to assist nurses to develop expanded roles within a collaborative practice model. At the regional level, a Family Healthcare Network would bring together all of the practice groups or networks to assist with system-wide planning in cooperation
with the District Health Council, the regional Ministry of Health offices and other regional providers of care. The Physician Facilitators would play key roles at the local and regional levels.

They blew Hospital Reform. What makes you think they won't blow primary care reform. Primary Care Reform should have preceded hospital reform. We should have had strong community-based services in place first. — Dr. D

To support patients, structures must be organized to facilitate collaborative relationships with a “patient first” orientation among healthcare partners throughout the system. The Health Services Restructuring Commission (HSRC) has recently identified the need for Ontario hospitals to be linked through the establishment of networks; this is a good first step. In addition to adequate community-based services, a community services network is needed to coordinate care between community-based agencies such as Community Care Access Centres, public health, ambulance, health and social services agencies and volunteer organizations that provide services to the community such as the Canadian Cancer Society, Heart & Stroke Foundation, Canadian Diabetes Association, etc. The Hospital Network and the Community Services Network should jointly ensure that systems are in place to provide easy access to services needed by the patients of Family Physicians. Currently, valuable time is spent on administrative tasks associated with accessing services and this needs to change. A 1-800 telephone access number is recommended. The HSRC model includes Joint Planning Committees among hospitals, Community Care Access Centres and District Health Councils which are addressing gaps and duplications in services. This model should be expanded to ensure that all providers of care, including Family Physicians, are at the table. Full integration of hospital networks with the community services (i.e., hospitals, long-term care, public health, Community Care Access Centres, ambulance, volunteer community agencies and health and social service agencies) with an interface between the Family Healthcare Network may be a reasonable model in many communities in Ontario but is not essential. Integration is not dependent upon institutional integration; it is dependent upon continuity of care being provided by the physicians regardless of the care delivery site. The aim of joint planning should be focused on development of systems to support the family physician as the integration of care from the patient’s perspective.

Table 6: Part 1 – An Integrated Delivery System: A Community Model

<table>
<thead>
<tr>
<th>Joint Planning Committee</th>
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<tr>
<td>· Hospital/Consultants</td>
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<tr>
<td>· Community Care Access Centres</td>
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<tr>
<td>· Public Health</td>
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<tr>
<td>Family Medicine</td>
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<tr>
<td>Family Physician Facilitator</td>
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</table>
In larger communities, the sheer volume of organizations may prohibit full integration of services; however, cooperative arrangements regardless of the size of the community are needed to provide timely access to the continuum of services for the patient-physician team. Service agreements should be developed to clearly identify links of accountabilities and communication in support of the patient-physician relationship.

She had a heart attack. They discharged her in 3 days with a prescription. She arrived in my office 10 days later with a bag of drugs and the unfilled prescription. She didn't know what she was supposed to be taking and neither did I. No one told me she was in hospital, let alone discharged. No home care, nothing. I called an ambulance and sent her back to the hospital. She was in failure and almost died. The system is screwy. — Dr. R

Many CCACs are caught between a rock and a hard place. Hospitals get quite aggressive when discharged patients don't receive care. The budget is too small, so services are being reduced for our most vulnerable people. It's the patients who suffer. — Mrs. K

I used to have a public health nurse come to the office. She was great – helped with well-babies, teens, seniors. Why did they pull out – budget I guess – always the budget. — Dr. A

Table 6, Part 2 presents a potential Regional Integrated Delivery System with strong Family Healthcare linkages between the hospital and community networks.

Table 6: Part 2 – A Integrated Delivery System: A Regional Model
It may make sense for hospitals to be responsible for an episode of care and provide “hospital-in-the-home” services for acutely ill discharged patients. This would free CCACs to better coordinate services for long-term and complex continuing care patients. This would ensure that patients are ready for discharge and the community is prepared to deliver the required services. Concern was expressed that hospitals are “dumping” patients into the community to reduce their costs without ensuring that adequate resources in the communities are available. This proposal would increase the accountabilities of hospitals making assessment of outcomes feasible. The public health nurses and nurse practitioners are seen as vital in assisting Family Doctors to provide appropriate health and wellness services.

The OCFP proposes that innovative models be tested in different areas of the province since no single model is likely to be the ideal in every region; however, in every community the role of the Family Physician as coordinator of care needs to be recognized and supported. Family Medicine needs to be seen as the hub of the system linking the different components of the system into an integrated whole from the patient’s perceptions.

Integration of the healthcare system can take place through vertical and horizontal integration of key components of the healthcare system. This may be difficult to orchestrate; however, the system can appear to be integrated to the patient if a Family Doctor, functioning as a *navigator* with the right information and the right support systems, is able to access and make sense of the various components of the system on behalf of the patient. To ensure that the patient receives the right care at the right time in the right place, the physician navigator and the patient must be able to access the best available evidence to develop an informed decision. By enhancing the role of Family Physicians as coordinators of care throughout the system and providing timely information and support, the patient will have ready access to a responsive healthcare system that provides easy access to affordable, quality services that focus on health promotion and health maintenance and excellence in healthcare.

### 2.10 The Healthcare Pyramid

Currently, today, the focus of the healthcare pyramid is on tertiary and secondary care:
The pyramid needs to be re-drawn to more clearly reflect the key role Family Physicians play in our healthcare system.
By placing the patient and the Family Physician at the top of the pyramid instead of at the bottom or on the periphery of the healthcare system, we will be able to develop a system that functions as an integrated whole from the patient’s perspective where it really counts.

### 2.11 Building on our Strengths

Despite the importance of Family Medicine, few changes in healthcare during the past decade have been directed towards the development of an infrastructure to support and maintain the patient-physicians relationship that is the heart of Family Medicine. Across Canada, primary care reform initiatives have been aimed at cost reduction and changes in physician remuneration. Many of the recommendations in this paper are similar to elements in the Ontario Primary Care Reform project but they are broader, more encompassing and reflect the feedback we received following the release of the original version of this paper. This paper reflects the broad scope of practice of Family Doctors which goes far beyond “primary care or first contact.” Family Medicine bridges the boundaries between community and institutionally based care and between health and healthcare to provide comprehensive care for patients.

As our population ages and our healthcare system becomes more complex and increasingly fragmented, patients are more reliant than ever before on their Family Doctor to pull the various components of the system together and thereby, make the system appear to be integrated from the patient’s perspective. But Doctors cannot deliver the comprehensive set of services described by PCCCAR and provide continuity of care without the help these recommendations will provide. These recommendations must, therefore, be implemented in their entirety if we
are to preserve our healthcare system for future generations. According to the Health Services Restructuring Commission, the economic case for the investment in an infrastructure for Family Medicine is sound. The support from the physicians and the public for moving forward is also strong. What is needed now is an action plan. The OCFP Board will develop an implementation pathway for consideration by government by June of 2000. We will continue to build bridges between the key healthcare stakeholders and generate the support to make this vision a reality.

3.0 FAMILY MEDICINE IN ONTARIO

3.1 The Four Principles of Family Medicine

Family Physicians are highly dedicated individuals. Currently, morale is at an all-time low because of Family Physician shortages and a system that provides disincentives for Family Physicians attempting to practice by the Principles of Family Medicine. Nearly 80% of our members report that the present system in Ontario promotes increased fragmentation of services and decreases the ability of Family Doctors to provide continuity of care to their patients. System changes required to improve the quality of patient care in keeping with the principles of Family Medicine, are as follows:

(a) **The Importance of a Trusting Relationship Between Physician and Patient**

The proven importance of the patient-physician relationship in the efficient delivery of healthcare must be recognized. The therapeutic relationship and the delivery of a defined set of patient services provides a basis for physician and patient accountability. By enhancing that relationship and by establishing the Family Physician as the coordinator of care through the continuum of healthcare services, the patient-physician partners will be more likely to access the right care in the right setting. This will help to improve care, control costs and reduce the negative impact on patients of an increasingly fragmented healthcare system. The end goal of restructuring should be a real or virtually integrated delivery system that facilitates access to affordable quality care and further enhances the physician-patient relationship.

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My doctor is great. He carries a pager. It is so reassuring to know that he is only a phone call away. I can call day or night if I need to. I don't but I could.

— Mr. T (liver transplant patient)

(b) **Providing Family Physicians with the Skills Communities Need**

The Ontario College of Family Physicians has always promoted the development of Family Physicians as highly skilled clinicians. Currently, there are very few opportunities for new graduates to obtain extra skills before they venture into the community to practice. This is especially difficult
for graduates who wish to practice in rural and remote areas. Excellent programs that develop high levels of skill in obstetrical care, emergency medicine, palliative care, mental health, care of the elderly and in many other areas exist in our current educational system, but there is insufficient funding for third year residency positions to allow interested residents to gain additional skills. Recent surveys have found that up to 90% of residents entering Family Medicine residency training programs wish to have extra training over and above the requisite two years. By the time they graduate, 40% would like further training, but positions are available for less than 10% of graduates at the present time. Programs such as emergency medicine have a very limited number of positions available and are greatly over-subscribed by residents wishing to seek additional skills in this area (over one-hundred applicants for four positions each year).

Physician human resource planning needs to take into account what doctors do. You may be able to handle more patients in the big city where most stuff is referred to specialists. Here we are the specialists, we are the only act in town showing. Likewise, our education needs to take into account the needs of rural communities. — Dr. C (Rural Physician)

Smaller communities require Family Physicians with different and specialized aptitudes, skills and knowledge than that required in communities with easy access to specialty services. By allowing young physicians to take extra training and provide them with the confidence they need to practice in smaller communities, recruitment and retention of physicians for rural and northern communities will be enhanced. Significant community benefits will occur from the delivery of a broader base of services made available by offering more opportunities for graduates to access extra training.

They just don't get it. Reducing standards if doctors from other countries agree to work in rural/northern communities doesn't make sense. You need more skills, not less, to work in the north. — Dr. R (Rural Physician)

My daughter is in medical school. Most of her classmates want to be Family Doctors and do their residency programs in a small hospital, not a teaching hospital. Rural Ontario is where doctors can really be doctors. — Dr. B

Canada’s current training system for Family Doctors is the shortest of any developed country in the world. Yet, the overall results are comparable or superior to those of the other countries. Part of the reason for the shorter training time in Canada is the major role Departments of Family Medicine play in undergraduate education. The combination of our undergraduate program and the two-year residency program provides a comparable level of knowledge and skills seen in the three-year programs in most other countries. Australia and Hong Kong require up to five years of extra training to achieve
A Canadian comparison with these two programs is also favorable. While our two-year Family Medicine program is more than able to prepare Family Physicians with the skills to provide comprehensive care in communities with adequate consultants and other allied healthcare professionals, many new graduates wanting to work in rural settings want additional training. A Canadian compromise should include government support to provide more third-year training positions for those who request these additional skills.

Academics try to provide CME for us. It doesn't work. They underestimate our knowledge base every time. They just don't understand Family Medicine. — Dr. C

Family Physicians who are already practicing in communities throughout Ontario are most in tune with their community’s needs and are very committed to meeting those needs. Many physicians who are already in practice have identified the specific needs of their community and wish to take additional training in anaesthesia, emergency, obstetrical and surgical care. Additional “re-entry” positions are required for physicians who are willing to return to the educational system to take extra training on behalf of their communities. Given the acute shortage of physicians in most communities, programs need to be developed with built-in flexibility to accommodate the needs of physicians who cannot abandon their patients and communities for extended periods of educational leave.

It’s so frustrating. We need an anesthesiologist here. One of our partners wants to be trained and the rest of us will cover for him. He can’t get into the program. — Dr. M

(c) Providing Care for a Defined Group of People in the Community

In our present system, the concept of the Family Physician as a resource to a defined practice population is not currently feasible as most Family Physicians do not currently serve a defined practice population. If citizens formally identified their own Family Physician and gave permission to manage their comprehensive electronic health record, that Family Physician would know each patient in the practice and could better support the health needs of the practice population. This strategy would encourage the provision of preventive services for the entire population. It would also give the Family Physician a sense of responsibility for a defined group of people. In the United Kingdom, a similar program has allowed for the development and promotion of effective programs to monitor people with chronic illnesses such as diabetes and hypertension. In addition, with Family Physicians more clearly accountable for health outcomes, doctors are more likely to ensure that optimal care would be provided and complications prevented. In Ontario, there are no incentives for prevention or health monitoring programs and
funds are not available to support collaboration with nurse practitioners or others to provide such programs.

I took over the practice of two doctors. There are a lot of charts back there but how many patients will come to see me is anyone’s guess. — Dr. B

(d) Increasing the Role of the Family Physician in Promoting the Health of the Community

Family Medicine is not really recognized in the fee schedule as a community-based discipline. In the current system, there are no financial supports or incentives for Family Physicians to participate in community outreach or education. Other funding options must be considered. For example, in a blended funding model (see Table 8), such activities would be seen as an important part of patient management. Educating the public in prevention and health promotion and self-care would be seen as important aspects of community-based care.

I was overwhelmed by psychiatric patients. I went out into the community, found some people who wanted to help. I taught them what to do and now they run great support groups. All pro-bono work, of course, but it sure has made a difference in our community. — Dr. S

Shifts in care delivery from institutional to community-based have occurred, but funding has not shifted in keeping with these directions. Due to early discharges from hospitals, people with more acute illnesses requiring more complex care are being cared for by Family Physicians instead of specialists. Care is now being delivered by community-based nurses and other providers. The increased number of patients needing to be seen and the role of the Family Doctor in supporting community-based caregivers have greatly increased the workload of Family Doctors; unfortunately, fee-for-service physicians are not funded for coordinating community-based care. Time spent coordinating patient care services with community services and agencies must be recognized financially. In future, funding models should have flexibility to respond to changes in care delivery.

3.2 Recognizing the Role of the Family Physician

Family Physicians are physician experts in providing comprehensive first contact care. There is a need for respect from colleagues to protect the core values of Family Physicians and the Four Principles of Family Medicine. An emphasis on “pride in craft” begins with support for educational programs. Traditionally, specialty training has been given greater recognition than Family Medicine. There needs to be strong recognition in our educational facilities that continuity of care and the development of a good therapeutic patient-physician relationship are mutually reinforcing and lead to enhanced care. Medical schools and residency
program must ensure that the academic environment is hospitable and supports the key role of Family Physicians in coordinating care through the continuum. To further enhance the discipline, opportunities for research in Family Medicine and continuing medical education must also be provided.
It starts in medical school. If you say you want to be a Family Doctor, they ridicule you “You’re are too smart. You should be a specialist.” — Dr. B

In each community, especially in the hospital sector, there needs to be recognition that the Family Physician is not only the vital first contact with the patient, but the member of the healthcare team providing the continuity of care that ensures quality outcomes.

Every time I see a patient with 2 ~ 3 specialists and no Family Doctor, a red flag goes up. Something always falls between the cracks. — Hospital Vice President

A well-established patient-physician relationship in which the Family Doctor is known and trusted by the patient, uniquely allows for “watchful waiting” as a strategy to deal with up to 40% of all new presenting problems. Many of the ill-defined and undifferentiated problems brought to Family Physicians never develop into a definable or serious diagnosis and are best managed by “watchful waiting”. The Family Physician requires a depth of knowledge of disease to accurately identify a problem as being serious or not and then to be comfortable in reassuring patients that they do not have a serious illness. For a trusted Family Physician, “watchful waiting” is a very successful strategy that can be implemented with little difficulty and with few investigations being required. In contrast, physicians who are unknown to the patient tend to order multiple investigations and consultations. This approach generates a great deal of cost for the system and unnecessary anxiety for the patient with little or no benefit.

Welcome to the antibiotic clinic. Honest, with my own patients I take the time to educate them and most often we try it without a prescription. Here it’s in/out. — Dr. A (walk-in clinic on-duty doctor)

Healthy outcomes from positive physician-patient relationships are known. Family Physicians must be reminded that their role is critical. Their understanding of Family Medicine and its role as a specialty in the delivery of continuity of care should help to restore “pride in craft” at a time when morale is at an all time low.

At the end of the day, if someone just said, “Thank you. You’re doing a great job.” It would help. — Dr. A

3.3 Addressing the Shortage of Family Physicians in the Province

If a broad-based basket of services is to be made available to every person of the province, there will need to be an adequate number of Family Doctors in the province. The Ontario College of Family Physician’s paper entitled “Where Have Our Family Doctors Gone: A Brief History of Family Medicine Shortages in Ontario” documents the evolution of the current shortage of physicians in the
province.\textsuperscript{48} The Ontario College supports the recommendations by the Society of Rural Physicians of Canada and by the Professional Association of Internes and Residents of Ontario (PAIRO) which is documented \textit{From Education to Sustainability: A Blueprint for Addressing Physician Recruitment and Retention in Rural and Remote Ontario} and in the key recommendations from PAIRO’s recent Forum ’99.\textsuperscript{49, 50, 51}

We recommend reopening the borders between provinces that now inhibit and discourage the free flow of physicians between provinces, as well as increasing the medical class size up to pre-1991 levels. The ratio of specialty to Family Practice first-year training positions should be altered from the current Family Physician / specialty ratio of 38:62 to a 50:50 ratio. The province might temporarily increase the number of foreign graduates allowed into provincial training programs (currently twenty-four per year) but must maintain the current academic standards for licensure.\textsuperscript{52} The OCFP believes that there should be more flexibility in the training requirements for foreign graduates. A further, more detailed paper entitled “Where Have Family Physicians Gone: Reversing the Trend” presented to the College of Physicians and Surgeons of Ontario outlines the OCFP’s process for accelerating the acceptance of graduates from foreign medical schools. The paper details a “Limited Special Education License” for these graduates and second year residents in Family Medicine.\textsuperscript{52} Two other papers developed by OCFP and entitled “Where Have All The Family Doctors Gone – Parts 3 & 4” provide further information on the doctor shortage.\textsuperscript{52}

3.4 Developing a “Patient Choice of Physician” System

If Family Physicians are to achieve continuity of care to promote positive community health outcomes, our members believe that every person of the province should choose a single Family Physician as their primary provider of healthcare. A broad spectrum of care with appropriate after-hour services should be provided to reduce pressures on Emergency Departments and the need for walk-in clinics. This proposed system would also facilitate the maintenance of a comprehensive electronic health record and improved information sharing.
You're not trying to bring in one of those HMO things from the States, are you? You know those things set up by insurance companies to save them money by depriving people of the care they need and paid for. Does the government like this plan? If so, forget it. — Talk Show Caller

The term “Patient Choice of Physician” avoids the term “rostering” which has come to have funding connotations. We believe that patients will choose a Family Physician they know and trust, particularly if the physician can provide the full scope of defined services and access to 24-hour 7-day per week urgent care through the group practice or network. Such a system could help to determine the number of physicians needed in any given community and throughout the province. The system lends itself to both patient and physician accountability for effective utilization of available resources and facilitates the determination of services the patient population in any community requires. Computerized information systems with the capacity to update the patient’s record is an essential component of the system and the advancement of Family Healthcare Information Systems needs to be a priority.

The “Patient Choice” system is based on the trusting relationship between the Family Physician and the patient. It is, therefore, important that patients and physicians have the right to terminate the relationship if either party feels that the relationship is no longer viable; however, changes should be restricted to 3–4 times in any given year. The OCFP maintains that the system will be more effective, personal and well-received by both the public and the profession if patients chose an individual physician rather than an institution or organization. The “Patient Choice” system has clear lines of accountability derived from the patient-physician relationship. Since over 90% of people in the province already identify with a Family Physician, the process of formalizing the relationship should be straightforward.

A survey of our members found that the majority were uncertain about the feasibility of a “rostered” system and clarity regarding patient and physician accountabilities will need to be delineated before the advantages of this approach can be realized. Informal consents rather than signed contracts should be used to allow the exchange of health information between the patient, the chosen physician and the healthcare team. The patient will give the physician and specified members of the team access to the electronic health record. Each person will be registered with only one physician in the province.

Some groups in Ontario would not be comfortable nor well served by a “Patient Choice” system. These individuals or patient groups may be better served by Community Health Centres. Advantages and disadvantages of a “Patient Choice of Physician” system are described in Table 7.
Table 7: Strengths/Weaknesses of a “Patient Choice System”
– from 3 Viewpoints: Patient, Family Medicine & System

<table>
<thead>
<tr>
<th>Strengths of Formal Patient Choice</th>
<th>Weaknesses of Formal Patient Choice</th>
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<tbody>
<tr>
<td><strong>Patients</strong></td>
<td><strong>Family Practice</strong></td>
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<tr>
<td>• Discourages double doctoring</td>
<td>• Encourages a more equitable distribution of Family Physicians</td>
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<tr>
<td>• Ensures maintenance of comprehensive healthcare records</td>
<td>• Identifies the adequacy of physician resources in the province</td>
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<tr>
<td>• Provides a tool for coordinating healthcare, health promotion and illness prevention</td>
<td>• Lends support to the <em>Four Principles of Family Medicine</em></td>
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<tr>
<td>• Attracts patients because of the broader range of services available</td>
<td>• Strengthens the ability to deliver continuity of care and monitors quality of care and health outcomes</td>
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<tr>
<td>• Builds a trusting relationship with the physician and other key healthcare providers</td>
<td>• Familiarizes people with and strengthens the understanding of the role of the Family Physician making it easier for both to track and understand physician resource issues</td>
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<tr>
<td>• Provides the ability to be a strong advocate for the patient in a complex system</td>
<td><strong>Healthcare System</strong></td>
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<td></td>
<td>• There may not be enough physicians to actually make it work</td>
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<td></td>
<td>• As a practice ages, the requirement for servicing that population will increase and make the practice more burdensome</td>
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<td></td>
<td>• Physicians may not like the lack of freedom to practice wherever they choose</td>
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<td>• Workload increases need to be addressed and adequately remunerated</td>
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<td></td>
<td>• Discourages over-servicing of patients or duplication of investigation through a centralized record</td>
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<td></td>
<td>• Data provides a more accurate demographic profile because of constant updating</td>
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<td></td>
<td>• Encourages networking between Family Doctors and other healthcare providers</td>
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<td></td>
<td>• Strengthens primary care services by encouraging networking and decreasing isolation of individual practitioners</td>
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<td></td>
<td>• Makes the gate-keeping role more feasible as the single Family Doctor to whom the patient relates has a better understanding of the resources individuals require</td>
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<td></td>
<td>• Improves communication within the institutions and, therefore, promotes the idea of integration</td>
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<td>• It could promote a two-tiered system if there was a difference in care between those in a practice and those who were not</td>
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<td></td>
<td>• The inappropriate use of Emergency Departments and walk-in clinics could continue if there is no mechanism for patient accountability</td>
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<td></td>
<td>• There will be a substantial increase in telephone work, patient demands, expectations</td>
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<td>• Information technology must be publicly funded</td>
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3.5 Developing a Collaborative Practice Model with Nurses

The Ontario College and its members are fully supportive of the expanded role of nurse practitioners. Some of our members have been working for some time in collaborative working relationships with a nurse practitioner or a Family Practice nurse. Seventy percent (70%) of the members surveyed would welcome the opportunity to work collaboratively with publicly-funded nurse practitioners to provide enhanced care within their scope of practice. Eighty-five percent (85%)
of our members reject the model of independent free-standing practice for nurses and midwives.\(^5^3\)

I keep hearing about how nurses can do 50% or 75% of what I do. What patient would want only 50% to 75% of the care they need? Nurses should tell people about the unique things that they do rather than trying to portray themselves as physician replacements. The nurse I work with is great, we complement each other. We don't compete. — Dr. W

Physicians recognize the knowledge and skills that nurses bring to a collaborative practice. Limits placed on their scope of practice by legislation restrict their ability to deliver all the PCCCAR services independently; however, collaborative practice supports continuity of care, provides preventative healthcare and improves the management of chronic illnesses. While nurses are unable to replace physicians, a mutually supportive role between Family Physicians and nurse practitioners is seen as major step forward in further developing Family Medicine as a specialty in the delivery of comprehensive care. To ensure accountability among team members, there is strong support for written collaborative practice agreements. The language should be clear and concise so that the roles and responsibilities of the partners are understood, not only by themselves, but also by their patients. Acceptable methods of accountability for physicians and nurses providing collaborative care will need to be developed. The liability of both partners in a collaborative practice partnership needs to be addressed and understood.

We need research and a task group of doctors and nurses to work through the issues.

— ‘Family Medicine Forum’ Participant

### 3.6 Building Quality Improvements into the System

Procedures exist through the College of Physicians and Surgeons and others to promote clinical accountability for physicians. Effective models for continuous quality improvement have been developed and could be more widely used in Family Practice settings.\(^3^9\) Peer accountability will provide motivation for individual improvement.

There is this guy in the community – no privileges at the hospital, so I can’t touch him – but we keep hearing things. Not enough to call CPSO but worrisome. — Dr. L (Chief of Staff)

In the United Kingdom, a system using arbitrarily fixed health targets and financial incentives as a means of improving health outcomes has been imposed upon general practitioners.\(^4^0\) However, a “report card” to the community on its health status is seen as the most appropriate method of assessing the effectiveness of care provided jointly by all members of the local healthcare system. The “report
card” is viewed as an important vehicle for achieving accountability to the community. The card should be developed by identifying specific community needs and monitoring how effectively they are being met by physicians and other providers of care. Community-wide clinical pathways should be developed for common health problems to provide all organizations with a clear understanding of their areas of responsibilities and accountabilities for individual patient care.

3.7 Developing Funding Options and Incentives for Providing Comprehensive Care

If the profile of the Family Physician in the new millennium described previously is to be achieved and sustained, working conditions for Family Physicians must be improved. During the last few years, Family Physicians have been concerned about the lack of incentives to practice medicine according to the College of Family Physicians of Canada’s four principles. Ninety-two percent (92%) of Family Physicians are currently paid using the “fee-for-service” model. Not only is there a lack of incentives, actual disincentives are in place.

I deliver good care to my patients. I’m fee-for-service. How dare you say that fee-for-service doctors don’t deliver comprehensive care to patients? — Dr. S

Incentives in the fee-for-service model tend to promote a narrower scope of practice and do not reward comprehensive or community care by the Family Physician. Hospital work, home visits, obstetrical services, etc. (by no means an inclusive list) take considerable time and are compensated at a relatively lower level compared with the fees paid for remaining in the office to see patients. While the current system encourages physicians to work in an office setting seeing many people for very short periods of time each hour, the majority of doctors prefer quality time with each patient and are not adequately reimbursed for doing so.

Care has shifted to the community but the resources to deliver that care haven’t. I spend all my time on the phone and filling out forms. I don’t get paid for any of those hours. — Dr. W

Family physicians are comparatively well reimbursed for working in emergency rooms, walk-in clinics and/or for operating room assisting, especially in urban areas where there are high volumes of minor problems seen that require minimal discussion. The current incentives encourage immediate referral of any significant problem so the next patient can be seen.

Over the past five years, a number of alternatives have been suggested to modify the way in which physicians could be paid. Table 8 lists the current models that are under discussion.
We're trying to negotiate an APP but no one will give us any information. Each group of doctors is negotiating in the dark. Why don't they find a way to just pay us fairly for the work we do? — Dr. T (Chief of Family Practice)

Table 8: Strengths/Weaknesses of Different Styles of Funding

<table>
<thead>
<tr>
<th>Description</th>
<th>Strength</th>
<th>Weakness</th>
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<tbody>
<tr>
<td>Fee-for-Service</td>
<td>• Avoids exploitation as only paid for work done</td>
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<td></td>
<td>• Rewards after hour shift</td>
<td>• Does not recognize FP as a skilled clinician</td>
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<td></td>
<td>• Familiar and accepted form of payment</td>
<td>• Encourages volume practice, avoidance of complex care, rapid turnover/recall</td>
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<td></td>
<td></td>
<td>• Driven by patient vs. MD</td>
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<td></td>
<td></td>
<td>• Disincentive for population medicine</td>
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<tr>
<td></td>
<td></td>
<td>• No benefit package</td>
</tr>
<tr>
<td>Salary</td>
<td>• Seniority can be recognized</td>
<td>• Issues re: autonomy</td>
</tr>
<tr>
<td></td>
<td>• Benefit packages</td>
<td>• Anti-MD undercurrents often encountered</td>
</tr>
<tr>
<td></td>
<td>• No productivity incentives</td>
<td>• Some MD’s have difficulty working in a multi-disciplinary environment</td>
</tr>
<tr>
<td></td>
<td>• Encourages care at level of patient need</td>
<td>• Employer/employee tension as MD’s not experienced in this role</td>
</tr>
<tr>
<td></td>
<td>• Rewards case conferencing</td>
<td>• Requires management structure – higher overhead</td>
</tr>
<tr>
<td>Capitation</td>
<td>• Flexibility to direct resources to address population health issue (patient centered approach)</td>
<td>• May create incentives for MD to select low risk, healthy patients</td>
</tr>
<tr>
<td></td>
<td>• Can keep FFS option if patients are high need</td>
<td>• Disincentive to refer patient to other MD’s/services when needed</td>
</tr>
<tr>
<td></td>
<td>• Self managing</td>
<td>• Inner city population-specific patient subgroups representative of the rest of population are not recognized by the model</td>
</tr>
<tr>
<td></td>
<td>• Facilitates independent nursing activities in selected areas</td>
<td>• Negated fees for MD if patient seeks care elsewhere – little disincentive for patient</td>
</tr>
<tr>
<td>CFPC Blended Funding Proposal (Table 9)</td>
<td>• Flexibility (could be patient centered via regional adaptation)</td>
<td>• Needs detailed but reasonable estimates</td>
</tr>
<tr>
<td></td>
<td>• Supports the principle of FM into the 21st century</td>
<td>• Potentially more complex administration</td>
</tr>
<tr>
<td></td>
<td>• Maintains/enhances skill sets of existing MD’s</td>
<td>• Potential to be physician centered</td>
</tr>
<tr>
<td></td>
<td>• Increased incentive for new MD’s to accept diverse roles</td>
<td>• Who determines levels of funding?</td>
</tr>
<tr>
<td></td>
<td>• Accommodate FFS benefits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Self managing</td>
<td></td>
</tr>
<tr>
<td>Alternative Funds global funding CHO</td>
<td>• MD group chooses how to provide service</td>
<td>• Fear loss of autonomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Shifts physician resources to fund other providers to affect access to MD and clinical volume vs. academic work</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• May allow payer to control MD numbers if funds are not MD dedicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• May impact upon specialists and hospitals innovative way (NHS experience)</td>
</tr>
<tr>
<td>Sessional/Contract Per Diem</td>
<td>• Rewards for work done</td>
<td>• No benefits, no security, no continuity</td>
</tr>
</tbody>
</table>

Our organization has always stated that no one model of funding should be imposed on the Family Physicians of the province, but each physician should be able to choose what is most appropriate for the practice setting. The funding principles that need to be followed include paying all physicians equitably for providing the same services, ensuring stable funding, benefits and retirement support for each physician. A word of caution comes from the British experience. Different funding models created two tiers of patient care, namely preferred and
non-preferred physicians. Fund-holding physicians were able to access quality services more easily than non-preferred. The resulting two-tiered system was very divisive and unacceptable. Funding models need to provide incentives for excellence in patient care with flexibility to promote physician satisfaction with the remuneration method.

Our survey of our members resulted in the following responses regarding preferred or acceptable funding methods.

Table 9: Funding Models

<table>
<thead>
<tr>
<th>Description</th>
<th>Preferred</th>
<th>Acceptable</th>
<th>Total Positive Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service</td>
<td>50%</td>
<td>41%</td>
<td>91%</td>
</tr>
<tr>
<td>Blended Funding</td>
<td>39%</td>
<td>39%</td>
<td>78%</td>
</tr>
<tr>
<td>Salary</td>
<td>12%</td>
<td>38%</td>
<td>50%</td>
</tr>
<tr>
<td>Capitation</td>
<td>7%</td>
<td>38%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Family Physicians have three priorities for any reimbursement system:

1. Reimbursement must reinforce the relationship between the physician and the patient rather than a government organization or institution.
2. There must be a stable source of funding.
3. There must be security for physicians in the system including benefit packages and retirement planning.

The blended funding model meets these requirements. Table 9 demonstrates that the model is quickly becoming very popular among our physicians. While most physicians still prefer fee-for-service, there is growing acceptance of the blended funding model. Salary and capitation models are seen as the preferred method by only 12% and 7% of the physicians surveyed.\(^{55}\) While health economists may promoted salary/capitation models, insistence on these funding models may be a major barrier to implementing the system.

There's all these people ripping off the system. Put doctors on a salary. Rostering and capitation will stop double doctoring and save taxpayers money. — Health Economist

They just don't get it. We give so much of ourselves each and every day. To be treated as a cost centre instead of valued members of society is so disheartening. — Dr. W
In July 1992, the College of Family Physicians of Canada (CFPC) released the document “A Proposal for a Blended Funding Mechanism”. With the rapidly changing economic environment as a result of mounting government debt, it is most timely to reassess the current methods of physician remuneration. Indeed, time is of the essence if we are to avoid being forced into payment mechanisms which are unfair to physicians, lack any incentive to improve quality of care and, in the end, discourage physicians from providing an appropriate volume of comprehensive services needed by their patients. The CFPC proposal rewards Family Physicians more appropriately for the services they provide and, in addition, will improve quality of care through encouragement of continuing medical education (CME), quality assurance programs, maintenance of certification, research, teaching, and maintenance of hospital privileges. The CFPC plan is also less volume driven yet provides incentives to maintain appropriate levels of service. With the plan’s emphasis on ambulatory care, comprehensive care and continuity of care, a decrease in overall healthcare costs can be achieved by avoiding unnecessary duplication of services and the higher cost of institutional care.

The CFPC proposal has 4 components:

(A) **Base**

A base salary would be paid for a minimum number of office hours per week and pro-rated for lesser hours of work. Also, an additional number of work units would be guaranteed within this time frame.

Included in the calculation of the base would be payment for:

(i) Holidays

(ii) CME

(iii) Pension contribution

(iv) Insurance – life, disability, medical/dental

(B) **Overhead Costs**

Overhead costs would be separated to ensure that income and expense are readily transparent to both the public and the physician. This section includes all cost related to:

(i) Rent

(ii) Equipment

(iii) Legal and Audit

(iv) Staffing/Administrative

(v) Information Technology/Health Record

(C) **Non-Volume Modifiers**

Incentives would be paid to encourage the participation of physicians in needed areas of care:

(i) Isolation allowance

(ii) Obstetrics

(iii) Maintenance of Certification

(iv) Teaching

(v) On-Call

(vi) Nursing Homes/Residential Care

(vii) Hospital Practice

(viii) Administration and Healthcare Planning

(ix) Acquisition & Maintenance of Special Skills

(x) Ambulatory Care

(xi) Research

(xii) Quality Assurance Programs

(xiii) Special Community Needs

(xiv) Psychotherapy

(D) **Volume Modifiers**

A numerical value is placed on individual work units. As each physician accumulates a total number of work units, he/she would fit into a specific category, each having a dollar value. Work units could be equivalent to the resource based relative value fee units each province is evolving, i.e.,

0 – 1000 units $A / 1000 – 2000 units $B / 2000 – 3000 units $C

No increase would be given over an agreed number of work units

or

A capitation type of remuneration could be used based on a patient roster.

In summary, the CFPC plan is a comprehensive proposal that allows for flexibility and pluralism. It promotes continuity, comprehensives and availability of care. It provides incentives for productivity and yet is not directly volume driven. It encourages the Family Physician to deliver appropriate high quality healthcare. It allows the Family Physician to assume the responsibility both for coordination of services and for the appropriate use of these services. It allows the Family Physician to be an effective team player within the multidisciplinary approach.
The Ontario College of Family Physicians finds that the blended funding model promotes the practice of the *Four Principles* more intensely than any other model. The blended funding model must support the Family Healthcare Infrastructure including improved information technology which is a major deficiency in the current system. The model must provide some type of benefits package for physicians including a retirement and disability plan (*Table 10*). The new volume modifiers need to include compensation for physicians working in remote areas of the province. In these communities, there are too few physicians available to share on-call responsibilities so the funding mechanism must recognize the burden of on-call duties assumed by these physicians. In addition, volume modifiers have the potential to recognize the workload impact of caring for patients with complex or difficult presentations such as seen in many inner city communities.

These disparities could be corrected by providing appropriate funding to the various components of the blended funding model. The blended funding model provides stability and security while maintaining autonomy for physicians. Volume modifiers and capitation components allow for bonuses to be provided for physicians working in remote areas or dealing with difficult populations (*Table 8*). The difficulties the United Kingdom experienced with one capitation fee being applied across the country is illustrated by the fact that the areas with difficult to service population characteristics became deficient in physicians. The blended funding model allows recognition of the heavy burden of some patients who need more time and energy to be cared for in a patient-centered model. It also acknowledges varying morbidity patterns within the province.

While the method of remuneration is important, another issue that is of major concern for Family Doctors has been the decline of income in relationship to specialist colleagues. In the 1970’s, the Ontario Medical Association stated that the ideal relationship between the average net income of Family Doctors and average net income of specialists should be approximately 80% of the average net specialist incomes for Family Doctors. With this background, the Ontario Medical Association stated that this relationship should not vary by more than 10% from the mean. Instead of narrowing the gap, it has increased. The 1999 report by the Ontario Medical Association stated that Family Physicians now receive only 62% of the average net specialist’s income. The heavy responsibility that falls upon Family Physicians currently must be recognized as equal to that of consultants. With the proposed new role, patient demands/expectations and medical-legal risks will increase significantly. Unless the disparity is addressed, Family Medicine will become increasingly unattractive as a career and unable to attract excellent new graduates to the discipline.
4.0 CONCLUSION

The Ontario College of Family Physicians is concerned that many planners of the healthcare system in Ontario have taken the role and services provided by Family Physicians for granted. We believe that implementing this proposal would improve access to quality healthcare for every citizen of Ontario. Although substantial investment would be required to start the new system, a significant improvement in the efficiency of the healthcare system would result ultimately in cost savings. A costing of a similar model to the one described in this document by Health Economists suggests that, investing in all components of the infrastructure needed to deliver the comprehensive patient choice model, would be cost-effective. Job satisfaction for Family Physicians would be improved as physicians would be able to practice according to the Four Principles of Family Medicine which would provide more benefits for the patients. An efficient and effective Family Physician work force and an enhanced role for nurses in a collaborative practice will provide patient-centred care that meets the needs of the public.

The implementation of this proposal should occur over the next three to five years with careful consideration given as to how to gain support and participation by the citizens of Ontario, Family Physicians, specialists and other healthcare providers. Attention should be paid to the role of nurses and nurse practitioners in the new system. Support for this proposal would affirm to the residents of Canada and Ontario that their healthcare system will remain a world leader. The support of all of the key stakeholders in Ontario is required to make our vision a reality. This discussion document will be used to gain consensus and support so that together we can build a better system that is sustainable over time in meeting the needs of the people of Ontario. As mentioned previously, a detailed implementation strategy will be available for consideration by June 2000.

There is nothing new here. This is the way my partners and I have been working for years. I guess what you are saying is all people in Ontario should have what our patients have. — Dr. M

Great work – keep it up. — Dr. H

If they understand what we mean when we say patient-physician relationship, they'll know that we are trying to improve patient care – big time. — Dr. G

I helped with the visioning exercise but I have also listened to what people are saying. Do I believe that this paper represents the right directions? – Absolutely. Do I think it will be a cakewalk? – No. Do I think we should move forward? – We have to. The public is depending on us. — Jan Kasperski (Executive Director, OCFP)
References


10. Primary Healthcare of the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR). *New Directions in Primary Healthcare*. July 1996, pp 5.


*Note: Complete copies of all references are on file at the OCFP office. Check our website at* [www.cfpc.ca/ocfp](http://www.cfpc.ca/ocfp)


Note: Complete copies of all references are on file at the OCFP office. Check our website at [www.cfpc.ca/ocfp](http://www.cfpc.ca/ocfp) for a copy of the paper. All references which are hyperlinked can be immediately accessed.


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Note: Complete copies of all references are on file at the OCFP office. Check our website at www.cfpc.ca/ocfp for a copy of the paper. All references which are hyperlinked can be immediately accessed.

Appendix 1

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Dr. John Hammett         Dr. Robert Washburn
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Dr. Kenneth Hook         Dr. Ruth Wilson
Dr. Andre Hurtubise      Ms. Jan Kasperski
Appendix 2

Participants in the Family Medicine Forum
September 1999

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  Ms. Mary Beth Valentine, Director, Program & Policy Branch

Health Services Restructuring Commission
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  Ms. Peggy Leatt, Chief Executive Officer

Ontario Hospital Association
  Ms. Susan Plewes, Director, President’s Office & Clinical Partnership

Ontario Medical Association
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  Dr. P. Stewart Kennedy, Chair, Section of General & Family Practice
  Dr. Wendy Graham, Chair, Primary Care Reform Committee

The College of Physicians & Surgeons of Ontario
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  Dr. David McLeod, Physician Advisor

Coalition of Family Physicians of Ontario
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  Dr. Michael Rachlis

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Appendix 2

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Dr. Gary Koop, Northern Region
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Moderator
Dr. David Gass, 1999 Donald I. Rice Scholar
Appendix 3

Definition of Family Medicine

“Family Medicine in Ontario is the provision of integrated and accessible healthcare services by Family Physicians who are accountable for addressing the majority of personal healthcare needs, developing a sustained partnership with patients resulting in continuity of care, a positive health outcomes. The focus of Family Medicine practiced within the context of family & community is on health promotion, disease prevention, community outreach and education, illness and curative services, rehabilitation and support services.”

Please Note: The definitions of the following terms used in the above may be found in the following sections of the document. By clicking onto each word, you will be able to access the specific sections directly.

integrated – Section 2.8 and 2.9.

accessible healthcare services – Using 24 / 7 coverage facilitated by nurse triage systems, networks or group practices and further enhanced by information systems. Section 2.7 parts (a), (b), (c) and (e).

accountable – The use of a facilitator. Section 2.7 (d).

majority of personal healthcare needs – The PCCCAR basket of services. Section 2.4 and 3.2 (b).

sustained partnership – The doctor-patient relationship. Section 2.1, 2.3, 3.2 (a) and 3.6.

family and community – Section 2.5 and 2.6.

* * * *

Definition of Family Healthcare Infrastructure

The term “Primary Care Reform” has, unfortunately, taken on new meaning and tends to evoke images of American-style HMOs. Amongst physicians, reflecting reduced access to care (gatekeeping), penalization (negation of physician income in response to patient actions) and increased workload without remuneration (doing more for less). For nurses, the term denotes “Primary Medical Care” and is exclusionary of health promotion, disease prevention and inter-professional collaborative practice. The term is not known or understood by the public whose main concern is access to a Family Doctor and necessary care. For the purposes of this document, the infrastructure needed to support the work of Family Doctors throughout the province will be referred to as the “Family Healthcare Infrastructure.”