OMA POLICY PAPER

Patient-Centred Care

Local Hospital Bylaw Issues
OHA professional staff prototype bylaws prompt physician concerns across Ontario

OMA Honours and Awards
Celebrating member accomplishments

Interpretive Bulletin
Fee codes, payment requirements for enhanced 18-month well baby visit and foot care services

Women’s Health
What’s new in prevention, physician leadership key topics at OMA Women’s Health Care Seminar

Insurance Update
Choosing an insurance advisor to meet your needs

Workplace Violence and Harassment
Online toolkit and guide help physician employers comply with new legislative requirements

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Editorial

The OMA is deeply concerned that the implementation of the OHA prototype bylaws as drafted will erode physician-hospital relationships in Ontario. We are working together with local physician leaders and grassroots members to encourage hospital boards to refrain from acting in haste in adopting the OHA prototype bylaws, and instead pursue a meaningful and consultative bylaw review process with medical staff and other health professionals.

OHA prototype bylaws prompt physician concerns across Ontario

A growing number of physicians in communities across the province are contacting the OMA to express concerns about local hospital bylaw issues, and the agenda set forth by the Ontario Hospital Association in its new professional staff prototype bylaws. A background article highlights the key areas of concern in the OHA prototype bylaws.

New employer requirements regarding violence and harassment in the workplace

The new legislative requirements under Bill 168 — the Occupational Health and Safety Amendment Act (Violence and Harassment in the Workplace) — are effective as of June 15, 2010. The OMA has prepared a comprehensive online toolkit to assist physician employers in understanding and complying with obligations under the amended legislation.

OMA 2010 honours and awards

The OMA hosted more than 250 physician honorees, their families, friends and colleagues at the recent OMA Gala Dinner and Awards Presentation in London. A photo feature highlights the award recipients by category, along with a complete list of 2010 honorees.

What’s new in prevention in women’s health

The recent 11th Annual OMA Women’s Health Care Seminar featured a range of topics, including strategies for the prevention and/or treatment of diabetes, gynecological cancer, and skin cancer; the latest information on the health effects of vitamin D; perspectives in international women’s health; and physician leadership.

New fee codes, payment requirements for enhanced 18-month well baby visit and foot care services

The bilateral Education and Prevention Committee has prepared an Interpretive Bulletin that describes a new service and fee codes for the enhanced 18-month well baby visit, as well as payment requirements for specific fee codes associated with foot care services.
Surprisingly, many physicians have not reviewed their insurance coverage in several years.

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Insurance Update: choosing an insurance advisor

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Practice Management: ending the physician-patient relationship

Physicians have a duty to act in the best interests of their patients and to provide them with quality service. But circumstances can arise that affect a physician’s ability to do just that. Ending the physician-patient relationship should not be taken lightly, but is sometimes necessary. The question is: When is it appropriate to terminate a patient relationship, and how should you do it?
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Publisher’s Notes continued

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The Ontario Medical Review is distributed to all members of the Ontario Medical Association. Others may subscribe to the Review at the following rates: in Canada $55; in the United States $62; in other countries $79 (Canadian funds). Single copies are $6, back issues $7. HST applicable as of July 1, 2010.

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A S THE ONTARIO MEDICAL REVIEW GOES TO PRESS THIS MONTH, THE OMA IS PREPARING TO HOST A MEETING OF PHYSICIAN LEADERS, HOSPITAL CHIEFS OF STAFF, AND MEDICAL STAFF ASSOCIATION PRESIDENTS FROM ALL CORNERS OF THE PROVINCE TO ADDRESS A BROAD RANGE OF HOSPITAL-RELATED ISSUES, NOTABLY THE CONCERNS AMONG PHYSICIANS ARISING FROM THE ONTARIO HOSPITAL ASSOCIATION’S NEW PROFESSIONAL STAFF PROTOTYPE BYLAWS.

Since April, we have provided several reports to members on this topic via our various communications channels.

The OMA believes the OHA prototype bylaws would diminish the role and input of physicians on local hospital boards, and could significantly impede physicians’ ability to advocate publicly on issues of patient safety and quality of care.

A background article on pages 10-11, prepared by the OMA Health Policy Department in conjunction with OMA Legal Services, provides a good summary of the many contentious areas within the OHA prototype bylaws.

We have provided our perspective to government and the news media on this issue. A recent front-page article in The Globe and Mail served to enhance public awareness of our concerns.

The OMA is planning various information sessions for colleagues to provide briefings and review the status of local hospital bylaws. Meeting announcements will be issued via e-mail and fax and co-ordinated with local physician leaders and staff.

The OMA website now features extensive information on hospital issues, including a variety of tools and resources to assist physicians to become engaged in the hospital bylaw development and revision process at the community level. An online survey is also available for members to provide input and share opinions and personal experiences on hospital-related matters.

The OHA is urging all hospitals to embrace the prototype bylaws and implement them quickly. It is the OMA’s understanding that some hospitals in the province are actively pursuing this direction.

The OMA Board of Directors discussed hospital issues at length during the recent June meeting. Our Hospital Issues Working Group, supported by various OMA professional departments, is communicating on a daily basis to review developments unfolding across the province, facilitate dialogue among members, and identify and prepare the resources required to support physicians at the community level.

The OMA is deeply concerned that the implementation of the OHA prototype bylaws as drafted will erode physician-hospital relationships in Ontario.

We are working together with local physician leaders and grassroots members to encourage hospital boards to refrain from acting in haste in adopting the OHA prototype bylaws, and instead pursue a meaningful and consultative bylaw review process in collaboration with medical staff and other health professionals.

This is an urgent priority and we will be providing updates to members on a regular basis. Physicians who require information or professional advice in responding to local hospital bylaw issues are encouraged to contact the OMA directly for assistance.

Dr. Mark MacLeod
OMA President
The OMA’s “Life’s Work” public information campaign has garnered international recognition for excellence in television advertising. Recently, the Telly Awards, an international body that honours the best in local, regional and cable television commercials, selected the OMA’s 30-second television spot for its highest honour in the Copywriting category, and a Bronze Award in the Corporate Image category. Developed in conjunction with Ottawa creative agency McMillan, the spot features OMA members sharing personal stories about why they chose a career in medicine, and how their experiences influence the care they provide to patients. The spot aired in major markets across Ontario during fall 2009.

"My life... ...inspires me... ...to care for yours."

ONTARIO’S DOCTORS:
Your life is our life’s work.
NEW LOOK!
OMR unveils fresh new design

This month, the Ontario Medical Review unveils a complete cover-to-cover journal redesign to enhance the magazine’s overall presentation and readability for more than 29,000 OMA members.

Every element of the publication, from the front cover and contents pages, to feature article formats, columns and classified ads, has been reviewed and refreshed.

With added colour and more openness throughout the pages, the new-look OMR depicts the Association’s visual standards, which govern the use of the OMA logo, typefaces and supporting graphics.

The Ontario Medical Review is a collaborative undertaking of editorial, production and administrative processes, which rely on the varied and highly valued contributions of OMA Sections and Committees, grassroots members and internal OMA departments and staff.

First published in 1922, the OMR is Canada’s third longest-running medical publication, and is one of the top-read medical publications among Ontario physicians.

The OMR strongly encourages membership input and feedback. Any comments or suggestions may be forwarded to Jeff Henry, editor, via e-mail (jeff.henry@oma.org) or telephone 1.800.268.7215, ext. 2963/416.340.2963.

Physician pension proposal

Physician pension plans are a topic of interest among many segments of the membership, and the OMA has been investigating pension options for Ontario physicians for some time.

As reported in the June 2 “President’s Update,” the OMA has submitted a report to the federal Ministry of Finance that proposes amendments to the Income Tax Act that would allow “affiliate pension plans” for the self-employed.

The OMA submission highlights the current realities and trends associated with retirement, and the broad social changes impacting Canadians’ traditional views of retirement. The OMA is advocating that affiliate pension plans be made available to all self-employed groups and associations across the country.

An affiliate pension plan would assist self-employed physicians to benefit from the advantages inherent in group pension plans, and provide enhanced options to members for financial security in retirement.

The OMA believes that when compared to a group RRSP, the affiliate pension plan model provides the best value for dollar by offering lower investment, annuity and longevity risks, cheaper administrative costs, and predictable monthly retirement income for life.

The 14-page proposal describes how an OMA plan might be designed and administered, member eligibility, and the OMA’s potential role and responsibilities as a plan sponsor. The report is available online (www.oma.org/Member/Resources/Issues/Pages/Pension.aspx).
FEATURE

Backgrounder

OHA Prototype Bylaws prompt physician concerns across Ontario:

hospital bylaw resources, member survey at oma.org

By Andrew MacLean
OMA Health Policy Department

A growing number of physicians in communities across the province are contacting the OMA to express concerns about local hospital bylaw issues, and the agenda set forth by the Ontario Hospital Association (OHA) in its new professional staff prototype bylaws. The OMA believes the OHA prototype bylaws, while only guides, would limit or discourage the important role of physicians in hospital decision-making, and increase the powers of hospital administration. The following article highlights key areas of concern in the OHA prototype bylaws. Additional resources on local hospital bylaw issues and a member survey are available on the OMA website.

The “professional staff” — physicians, dentists, midwives, and nurse practitioners

In the OHA prototype bylaws, the group of physicians known as the Medical Staff is now a part of a “professional staff,” which includes nurse practitioners, midwives, and dentists. While the term Medical Staff exists, it is meant to be one of four staff categories that together comprise the professional staff.

Mandatory on-site interviews before applications go to Medical Advisory Committee (MAC)

The OHA prototype bylaws contain a new requirement that all applicants, before they officially apply to be a member of the professional staff, must visit the hospital corporation to be interviewed — only then will their application for appointment be considered. It is unclear why the applicant must visit the hospital corporation before his or her application may be actually considered, and why the CEO should attend the interview.

The definition of “privileges,” and its implications for physicians

The new OHA bylaws also define “privileges” for the first time. Privileges are defined as “the right to admit inpatients, register outpatients and/or provide the clinical services which the Board has granted to a member of the professional staff.” The courts have actually provided that the definition is broader than that, and there is a substantial danger in agreeing with this restricted interpretation, because it reduces the rights of physicians to access hospital resources necessary for patient care.

Personal and private information required of physicians

To even apply for appointment to the professional staff, there is a requirement for “information regarding the applicant’s health, including any impairments, medical conditions, diseases or illnesses (including social health problems, alcohol or drug abuse, or attempted suicide) that may impact on the applicant’s ability to practice,” and “if requested, an authorization to the treating health professional to release information to the Hospital.” “Social health problems” are not defined, and it is difficult to believe that in the 21st century, attempted suicide would carry a stigma for purposes of applying for privileges.

Potential duties and obligations of physicians to the hospital

Under the OHA bylaws, a physician would have a duty to “serve as may be requested on various hospital committees,” and the physician’s “discharge and performance on staff and committees” is a suggested matter to be part of annual reviews (Appendix II.5.2). By requiring physicians to be part of hospital committees, the hospital has increased control over physicians’ time and hospital roles.
The hospital’s “standing in the community”
Physicians would also have a duty to “not undertake any conduct that would be disruptive to the Department or affect hospital operations.” Though this could be broadly interpreted, it aligns with recent disruptive physician initiatives. However, in the same statement, physicians are also not to undertake any conduct that would adversely affect “the Hospital’s reputation or standing in the community.” This is unacceptably broad.

On-call rotation participation
The OHA bylaws state that as applications are submitted for appointment to the corporation’s professional staff, the applicant acknowledges that any granted privileges extend to all sites of the corporation, if appropriate. What happens if the physician only wishes to practise at one hospital site, even though privileges are granted for all sites? Does the granting of privileges across all sites bring with it a requirement to deliver services or be placed on-call for multiple sites? This remains open to interpretation.

Information relating to past investigations, findings, and disciplinary actions
Applicants for privileges are to provide descriptions of “pending, ongoing, or completed” disciplinary actions, investigations, performance reviews, disputes with other hospitals over privilege-related issues, any civil suit “which was settled by a payment,” or in which there was actually an adverse finding, or pending or ongoing civil actions or criminal charges. Asking for pending or ongoing investigation information could prejudge the outcome of the investigation, and concerns the Canadian Medical Protective Association (CMPA). In the same vein, asking for information about processes that were settled by payment is irrelevant; settling an issue by payment is not an admission of liability.

Recognizing the authority of hospital administration
The OHA bylaws stipulate that when the chair and vice-chair of the MAC are absent, the chair of the MAC must now consult the CEO when designating an alternate to act on his or her behalf, but there is no mention of consulting other members of the MAC.

Physician participation in the development and formulation of local hospital bylaws is encouraged.

The OMA is available to assist members.

Restrictions and suspensions of privileges
A professional staff member’s privileges may be temporarily and immediately restricted or suspended where, in the opinion of the CEO or MAC chair, the member does “not comply with criteria for annual re-appointment; fails to comply with the hospital’s bylaws, rules, and regulations, the Public Hospitals Act, or any other relevant law; or is reasonably likely to be detrimental to patient safety or to the delivery of quality patient care within the hospital or impact negatively on the operations of the hospital.” In contrast, the CMPA recommends that temporary suspensions of privileges be restricted solely to situations of danger, and then for only as long as the danger exists.

Outline of bylaw update processes and how physicians can participate
Hospitals are not required to follow the OHA Prototype Bylaws, but the OHA has encouraged its own members to often updated at the same time; physicians should be equally aware of all proposed revisions to hospital policies and procedures.

Several resources are available on the OMA website (http://www.oma.org/health/professional/) to assist members in their efforts to better inform colleagues and their local hospitals. Also on the website is a survey, where members are encouraged to provide their views on local hospital matters. This helps the OMA provide the right tools and strategies to assist members as they engage collaboratively with local hospital stakeholders.

Physician participation in the development and formulation of local hospital bylaws is encouraged, and members should inform themselves about how they can contribute to their local hospital’s bylaw revisions process when it unfolds.

For further information, contact Andrew MacLean, OMA Health Policy Department, via e-mail (andrew.maclean@oma.org).
Feature

Occupational Health and Safety Amendment Act

New employer requirements regarding violence and harassment in the workplace: resources available to assist physicians

By Juhee Makkar
OMA Health Policy Department


To assist employers in complying with the amendments, the Occupational Health and Safety Council of Ontario (OHSCO) has prepared a set of materials entitled “Workplace Violence Prevention Series,” which includes a comprehensive “guide” and “toolbox” for employers’ use. These materials are available on the Ministry of Labour website (www.labour.gov.on.ca).


• The toolbox, which contains a number of general templates and suggestions that can be adapted to specific workplaces, is available online at: http://www.labour.gov.on.ca/english/hs/pdf/wvps_toolbox.pdf.

The OMA also encourages physicians to familiarize themselves with the Ministry of Labour document entitled “Workplace Violence and Harassment: Understanding the Law,” which is posted online at: http://www.labour.gov.on.ca/english/hs/pdf/wpvh_gl.pdf. This document explains what employers and employees need to know about workplace violence and harassment, and their respective legal duties.

The OHSCO toolbox contains flexible template assessments that can be tailored to a physician’s particular workplace. Prior to conducting the assessment, physicians may wish to gather input from employees, review previous incidents of violence, and consult existing policies to determine what works well.

Specific risks in the health-care environment can include direct contact with patients, working with unstable or volatile clients, or working in a community-based setting. The toolbox presents sample assessments for each type of specific risk.

Policies and Programs

The Act compels employers to create policies and programs for implementation for both workplace violence and harassment. However, the policy is only required to be in writing, and visibly posted in the workplace, if six or more workers are regularly employed. If there are fewer than six employees,
the policy does not have to be in writing, unless ordered by a Ministry of Labour inspector.

The workplace violence and harassment policies are intended to be high-level statements indicating that the employer is committed to protecting workers, and will investigate and deal with any situation that may arise.

The workplace violence and harassment programs should outline methods for reporting incidents, investigation, and for obtaining immediate assistance.

Finally, the workplace violence program must include measures and procedures that control the risks identified as part of the workplace assessment.

The toolbox provides assistance in developing these programs, and also contains template policies for employers to follow.

Domestic Violence

Bill 168 has created a substantial duty for employers with respect to domestic violence. An employer who is aware, or ought reasonably to be aware, that domestic violence may occur in the workplace must take every reasonable precaution to protect the worker.

Assessing the threat of domestic violence is not a straightforward task and could pose considerable challenges for the employer. The toolbox lists a number of signs of domestic violence, and suggests how to create a safety plan for employees that are potential victims.

The Ministry of Labour document entitled “Workplace Violence and Harassment: Understanding the Law” also presents helpful answers to several frequently asked questions to assist employers in detecting and handling instances of domestic violence. For example, the document specifies that an employer may be required to take action to protect a targeted worker, even if that individual does not desire that any steps be taken.

Education and Training

Employers must educate workers about the contents of the workplace violence policy and program as part of their general duty to provide information and instruction that protects employee health and safety. In addition, an employer may reveal personal information about an individual with a “history of violent behaviour” if it is likely that this individual will subject a worker to physical injury. Employers may struggle with this obligation given obvious privacy concerns, and the difficulty associated with determining whether someone has a history of violent behaviour.

According to the OHSCO guide, “Developing Workplace Violence and Harassment Policies and Programs: What Employers Need to Know,” employers may choose to set procedures for informing workers about a person who has a history of workplace violence. This could be added to the workplace violence program.

To obtain additional clarification, “Workplace Violence and Harassment: Understanding the Law” has a useful series of questions about persons with a history of violent behaviour, and when disclosure is appropriate.

Physicians should always be mindful about balancing an individual’s privacy rights against an employee’s right to be informed of workplace violence risks. If you are unsure about how to fulfil your duty in such a circumstance, the Ministry of Labour suggests obtaining legal advice. Physicians can contact the OMA Legal Services Department for assistance (see contact information below).

Conclusion

The OMA supports efforts to prevent and decrease workplace violence and harassment. As both employers and employees, physicians have an interest in maintaining a safe and accountable work environment. The OMA is currently working on consolidating information contained in the OHSCO and Ministry of Labour materials that pertains specifically to physician work environments.

To obtain further assistance or clarification regarding Bill 168, please contact Juhee Makkar, OMA Health Policy Department, via e-mail (juhee.makkar@oma.org), or Adam Farber, OMA Legal Services Department, via e-mail (adam.farber@oma.org).

Footnote

1. The Act does not require an assessment of the risk of workplace harassment.
HELPING YOU ACHIEVE A BETTER BALANCE

The OMA Physician Health Program is a confidential service for physicians, residents, medical students and their family members who may be experiencing problems ranging from stress, burnout, emotional or family issues, through to substance abuse and psychiatric illness. The OMA Professionals Health Program is a confidential service provided to health professionals.

Confidential Toll-Free Line 1.800.851.6606
php.oma.org
## 2010 OMA Award Recipients

**Canadian Medical Association Honorary Membership Awards for Ontario Members**
- Dr. Michael Thoburn, Waterloo
- Dr. H. Ronald Wexler, London

**Ontario Medical Association Life Membership Awards**
- Dr. Karen Cronin, Toronto
- Dr. Nenad Gagic, Hamilton
- Dr. Donald J. Harterre, Peterborough
- Dr. David Palframan, Ottawa
- Dr. Stewart O. Pugsley, Hamilton
- Dr. Charles S. Shaver, Ottawa
- Dr. Hans J. Steizer, Peterborough
- Dr. David W. Swales, Peterborough
- Dr. Michael Thoburn, Waterloo
- Dr. H. Ronald Wexler, London
- Dr. John A. Wright, Owen Sound

**Ontario Medical Association Honorary Membership**
- Dr. David Pattenden, Kingston

**Distinguished Service Award**
- Dr. Rayudu Koka, Sudbury

**Advocate for Students Award**
- Dr. D. Anna Jarvis, Toronto

**Presidential Award**
- Dr. Roy Rowsell, Enniskillen

**Resident Achievement Award**
- Dr. Zainab Abdurrahman, McMaster University, Hamilton
- Dr. Behnam Banihashemi, University of Toronto, Toronto
- Dr. Ceara McNeil, University of Western Ontario, London
- Dr. Mark Preston, University of Ottawa, Ottawa
- Dr. Jennifer Tang, Queen’s University, Kingston

**T.C. Routley Challenge Shield Award**
The London & District Academy of Medicine

**Glenn Sawyer Service Award Recipients**
- Dr. Thomas Baitz, Cornwall
- Dr. David Berbrayer, Toronto
- Dr. Clive Davis, Hamilton
- Dr. Wayne B. Domanko, Morrisburg
- Dr. Robert W. Farley, Brantford
- Dr. Donald H. Ferguson, Carleton Place
- Dr. Reinhard Friesen, Peterborough
- Dr. Raymond D. Kiff, Orillia
- Dr. Curtis Milner, Sudbury
- Dr. Robert Moulson, Thunder Bay
- Dr. Ashnoor Nagji, Toronto
- Dr. K.N. Reddy, Niagara Falls

**Community Service Award**
- Mr. Gabriel Belanger, Sudbury
- Ms. Shirley Broekstra, Toronto
- Ms. Connie Martin, Leamington
- Mr. Ken McMullen, Orillia
- Ms. Carolyn Milne, Hamilton
- Chief Daniel Parkinson, Cornwall
- Ms. Dawna Ramsay, Ottawa
- Mr. Carl White, Thunder Bay

**Medical Student Achievement Award**
- Andrew Boozary, University of Ottawa, Ottawa
- Andrew D. Brown, University of Toronto, Toronto
- Kyle Cullingham, Northern Ontario School of Medicine, Thunder Bay
- Karmen Krol, Queen’s University, Kingston
Ontario Medical Association Life Membership Awards
OMA Life Membership is awarded to those members who have made an outstanding contribution to the works of the Association, the medical profession and medical science, or common good at the provincial level, and have reached the age of 65 as of December 31 in the year preceding the OMA Annual Meeting that the awards are to be presented. Under exceptional circumstances, candidates under 65 years of age may be considered. The 2010 recipients are listed below.

Dr. Karen Cronin
Toronto

Dr. Nenad Gagic
Hamilton

Dr. Donald J. Harterre
Peterborough

Dr. David Palframan
Ottawa

Dr. Stewart O. Pugsley
Hamilton

Dr. Charles S. Shaver
Ottawa

Dr. Hans J. Stelzer
Peterborough

Dr. David W. Swales
Peterborough

Dr. Michael Thoburn
Waterloo

Dr. William S. Tucker
Toronto

Dr. H. Ronald Wexler
London

Dr. John A. Wright
Owen Sound
Canadian Medical Association Honorary Membership

Awards for Ontario Members

CMA Honorary Membership is awarded to those members who have made outstanding contributions to the CMA on its Board of Directors, Committees, General Council or to Canadian medicine. CMA Honorary members from Ontario are nominated by the Board of Directors of the OMA, and elected by unanimous vote of the Board of Directors of the CMA. Members will have reached the age of 65 and have been active members of the CMA for the preceding 10 years. This year’s recipients are Dr. Michael Thoburn, Waterloo, and Dr. Ronald Wexler, London.

Dr. Michael Thoburn
Waterloo

Dr. H. Ronald Wexler
London

Ontario Medical Association Honorary Membership

Honorary membership is awarded for having achieved eminence in science and/or humanities, such as outstanding services to the OMA, the medical profession, medical science or common good at the provincial level. This year’s recipient is former OMA CEO Dr. David Pattenden.

Dr. David Pattenden
Kingston

Distinguished Service Award

The Distinguished Service Award is awarded to a member of the Association for exceptional long-standing service to the OMA and the patients of Ontario. This year’s recipient is Dr. Rayudu Koka, Sudbury.

Dr. Rayudu Koka
Sudbury

Advocate for Students Award

The Advocate for Students Award is presented to a physician or non-physician in recognition of outstanding contributions that have significantly benefited the medical students of the province of Ontario. This year’s recipient is Dr. D. Anna Jarvis, Toronto.

Dr. D. Anna Jarvis
Toronto
2010 OMA Awards Ceremony

Resident Achievement Award
The Resident Achievement Award is awarded for outstanding contribution to the advancement of postgraduate training. As of 2007, the award may be presented annually to one resident from each of the six provincial medical schools. The 2010 recipients are listed below.

Dr. Zainab Abdurrahman
McMaster University
Hamilton

Dr. Behnam Banihashemi
University of Toronto
Toronto

Dr. Ceara McNeil
University of Western Ontario, London

Dr. Mark Preston
University of Ottawa
Ottawa

Dr. Jennifer Tang
Queen’s University
Kingston

T.C. Routley Challenge Shield Award
Donated in 1947 by Dr. T. Clarence Routley, the first full-time Secretary of the OMA from 1918 to 1938, this award is given to the Branch Society which, through its programs and activities, most adequately fulfils the objectives of service to its members, its community, and the medical profession. This year’s recipient is the London & District Academy of Medicine.

NOMINATIONS FOR 2011 AWARDS
Nominations for awards to be presented in 2011 should be sent to the OMA no later than November 1, 2010. E-mail: Mary Ng (mary.ng@oma.org), or tel. 416.599.2580 or 1.800.268.7215, ext. 2999.
The City of London recently hosted the OMA Annual General Meeting (AGM) for the seventh time in the Association’s 130-year history. OMA Archives has prepared a look back at the first time London hosted the OMA AGM in 1885. Approximately 130 physicians attended that fifth OMA Annual General Meeting; a two-day event held June 3-4, 1885, at Victoria Hall in London.1

At right is a copy of the original letter from then OMA President Dr. Addison Worthington to the physicians of Ontario, informing them of the London meeting. In his letter, Dr. Worthington highlights the Association’s efforts to raise the standards for the medical profession, and further the cause of public health.

Delegates at the 1885 AGM heard presentations on a range of topics, including diphtheria, intra-uterine medication, cocaine, obstinate sciatica, urinary calculi, surgical sequelae of exanthemata, placenta previa, intestinal obstruction, pulmonary cavities, and the use of plaster splints in surgical practice.

Business matters included the appointment of new OMA President Dr. George Tye of Chatham. And, a notable visitor at the meeting was Dr. William Brodie, President of the American Medical Association.2

Physicians who possess any historic items they feel may be of interest to the OMA Archives are encouraged to contact Ian Wolfe, OMA Information Management Department, at: ian.wolfe@oma.org.

References
EARLY DETECTION OF DISEASE, COMBINED WITH THE REDUCTION OR ELIMINATION OF BEHAVIOURS PROVEN TO HARM HEALTH, AND THE ADOPTION OF STRATEGIES SUCH AS A GOOD DIET AND EXERCISE, ARE GENERALLY CONSIDERED TO BE KEY FACTORS IN PREVENTING ILLNESS AND MAINTAINING LONG-TERM HEALTH.

Disease prevention has, in fact, become an important focus for a growing number of individuals, both within and without the health-care community.

It was with this in mind that the OMA Outreach to Women Physicians Committee selected “What’s New in Prevention in Women’s Health” as the theme for the 11th Annual Women’s Health Care Seminar, held in London, Ontario, during the recent OMA 2010 Annual General Meeting.

The Women’s Health Care Seminar continues to be among the most popular events offered during the OMA AGM, with more than 65 physician participants in attendance this year.

Seminar presentations covered a range of topics, including perspectives in international women’s health; strategies for the prevention and/or treatment of diabetes, gynecological cancer, and skin cancer; the latest information on the health effects of Vitamin D; and concepts on addressing problems using an inquiry-based approach.

International Women’s Health
The morning session began with an inspiring keynote address by Dr. Samantha Nutt, Founder and Executive Director of War Child Canada. In a presentation entitled “Perspectives in International Women’s Health — Where Advocacy Meets Medicine,” Dr. Nutt discussed her experiences working on human rights issues in countries such as the Democratic Republic of Congo and Sierra Leone.

The emotionally charged talk provided participants with an outlook on how to utilize leadership skills on a global scale. Dr. Nutt was candid about the danger, human suffering and death she had witnessed while out in the field, but rather than taking a nihilistic approach, she provided relevant advice to audience members on the small ways they could make a real difference. For example:
1. Read international news (to stay current on issues affecting other parts of the world).
2. Make a commitment to a charity/cause that you care about.
3. Be a socially responsible consumer.
4. Think about “life and loss” in a global sense as opposed to just your own country or neighbourhood.

Dr. Nutt’s address was followed by three separate presentations on the topic of disease prevention with respect to diabetes, gynecological cancer, and the role of vitamin D.

- Dr. Irene Hramiak, chair, Division of Endocrinology and Metabolism, St. Joseph’s Health Care, London, spoke about the prevalence of Type 2 diabetes mellitus. She discussed disease prevention strategies, including lifestyle modifications, and medications that are currently available to treat diabetes.
- Dr. Joan Murphy, associate professor, University of Toronto, explored the role of HPV in cervical cancer, as well as cancer-reduction strategies in ovarian and other gynecological cancers. Dr. Murphy discussed the potential impact of the HPV 16/18 vaccination in “preventing the development of associated pre-cancerous cytological and histological changes, as well as invasive cervical cancer.”
- In the final presentation of the morning, Dr. Reinhold Vieth (PhD), professor, Department of Nutritional
Leadership
OMA Past-President Dr. Suzanne Strasberg delivered the seminar’s luncheon address. Dr. Strasberg spoke about the many challenges and triumphs she experienced during her time as President, and offered advice to physicians looking for opportunities to participate in various facets of health care.

“While we are becoming more diverse, and we know that student enrolment in medical schools is now averaging 50 per cent to 60 per cent female, we are still behind in the number of women who are taking up leadership positions,” said Dr. Strasberg. “I know many of us have families and other obligations to tend to, and we work long and hard in our busy practices, but I am convinced that our role as patient advocates and as physicians extends beyond the examining room. It is essential that we get involved as we have invaluable knowledge and expertise — and as female physicians, we have different perspectives and backgrounds that should be brought into policy discussions.”

The afternoon portion of the seminar shifted focus from disease prevention to the development of leadership skills.

As part of the new OMA Physician Leadership Development Program, a workshop session entitled “Leadership and the Power of Inquiry” was presented by Dr. Brenda Zimmerman (PhD), director, Health Industry Management Program, and associate professor of strategy/policy, Schulich School of Business at York University.

With a focus on the power of formulating appropriate questions in order to solve difficult problems, Dr. Zimmerman had participants work in small groups in order to discuss the types of questions and leadership approaches they have used in the past. She then challenged them to seek new leadership techniques to use not only in their practices, but also to help guide the ever-changing health-care system in Ontario.

“Prevention in Dermatology” was the topic of the final session of the day, presented by Dr. Denise Wexler, community dermatologist, and vice-president, Canadian Dermatology Association. Dr. Wexler spoke about skin cancer recognition and prevention, and provided methods of preventing long-term skin damage. She also discussed the effects of cosmeceuticals and Botox.

Acknowledgments
The Women’s Health Care Seminar concluded with a wine and cheese reception that provided participants with an ideal opportunity for some informal networking.

A brief presentation took place to honour the outgoing Chair of the Outreach to Women Physicians Committee (OWPC), Dr. Joy Weisbloom, who served on the Committee for six years, and was Chair for the past four. Dr. Gail Beck, OMA Board Member and OWPC Board representative, presented Dr. Weisbloom with a small token of appreciation, and thanked her for her continued leadership.

The OWPC would like to thank all of the participants who attended this year’s seminar, as well as the presenters for making this yet another successful event. We look forward to hosting the 12th Annual Women’s Health Care Seminar on April 28, 2011, in Toronto.

To view selections from the 2010 seminar presentations, please visit the OMA website (https://www.oma.org_MEMBER_Community_WomenPhysicians/Pages/default.aspx).

Update on Outreach to Women Physicians Committee
The OWPC would like to congratulate Dr. Rachel Forman, who was acclaimed incoming Committee Chair. Dr. Forman is a Toronto-based obstetrician-gynecologist with a subspecialization in reproductive endocrinology and infertility, and has served as an OWPC Committee member for more than three years.

The OMA Board has also elected two new OWPC Committee members: Dr. Sandi Plant of Brantford, and Dr. Suzanne Alain of Thunder Bay. Drs. Plant and Alain began their terms on June 15.

Federation of Medical Women of Canada
The Federation of Medical Women of Canada (FMWC) is hosting its annual general meeting on September 25-26, 2010, at the Intercontinental Hotel in Toronto. The theme for this year’s AGM is “The Many Faces of Medical Women.” The event will offer seminars on leadership and women’s health.

The OMA will be hosting a wine and cheese reception for FMWC registrants on September 24 (from 6:00 p.m. onwards) at the OMA office (located at 150 Bloor St. West in Toronto).

The OMA will also be leading a panel discussion entitled “Woman as Politician: The Process of Advocacy,” featuring OMA Past President Dr. Janice Willett (2007-2008), along with other influential women physician speakers.

For more information, or to register for this event, please visit the FMWC website (http://www.fmwc.ca/index.php?page=430).

Hosting local events
Physicians who are interested in hosting a local women’s outreach event in their area, or who have any questions regarding the Outreach to Women Physicians Committee and/or the Annual Women’s Health Care Seminar are encouraged to contact Sampada Kukade, OMA Public Affairs and Communications Department, via e-mail (sampada.kukade@oma.org), or phone 1.800.268.7215, ext. 2970.
1. Dr. Brenda Zimmerman (PhD)
2. Dr. Reinhold Vieth
3. OMA Outreach to Women Physicians Committee members (from left): Dr. Rachel Forman (chair), Laura Lachance (third-year Queen’s medical student observer), Dr. Joy Weisbloom (past chair), Dr. Gail Beck (OMA Board representative), Dr. Kelly Grant.
4. Dr. Samantha Nutt
5. Dr. Denise Wexler
6. Dr. Joan Murphy
7. Dr. Suzanne Strasberg
8. Dr. Irene Hramiak
Early in Practice -
The Essentials You Need to Know
Are you starting your professional career in medicine, or completing your residency? Topics include:
- Differences between insured & uninsured services
- Legal considerations in starting a practice
- OHIP and WSIB billing and claims
- Insurance for your personal and professional life

Dates & Locations:
September 29, 2010 (4:00pm - 8:00pm) - Ottawa, ON
October 6, 2010 (4:00pm - 8:00pm) - Hamilton, ON

Billing Information & Support
Are you currently practicing? Find out how to optimize your billing opportunities. Topics include:
- Fees for third party and uninsured services
- Different primary care payment models available
- Billing for the Family Health Organizational model

Dates & Locations:
October 27, 2010 (3:00pm - 8:00pm) - Windsor, ON
November 12, 2010 (10:00am - 3:00pm) - Toronto, ON

Space is limited at these seminars. For more information, please contact us by phone at 416.599.2580 or 1.800.268.7215 ext. 3088, or by e-mail (practiceadvisory@oma.org). Dates and locations of seminars are subject to change.
INTRODUCTION
What is the Education and Prevention Committee (EPC)?
The Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA) have jointly established the Education and Prevention Committee (EPC). The EPC’s primary goal is to educate physicians about submitting OHIP claims that accurately reflect the service provided so that the need for adjustment of inappropriately submitted claims is reduced.

What is an Interpretive Bulletin?
Interpretive Bulletins are prepared jointly by the Ministry and the OMA to provide general advice and guidance to physicians on specific billing matters. They are provided for education and information purposes only, and express the Ministry’s and OMA’s understanding of the law at the time of publication. The information provided in this Bulletin is based on the October 1, 2009 Schedule of Benefits – Physician Services (Schedule). While the OMA and Ministry make every effort to ensure that this Bulletin is accurate, the Health Insurance Act (HIA) and Regulations are the only authority in this regard and should be referred to by physicians. Changes in the statutes, regulations or case law may affect the accuracy or currency of the information provided in this Bulletin. In the event of a discrepancy between this Bulletin and the HIA or its Regulations and/or Schedule under the regulations, the text of the HIA, Regulations and/or Schedule prevail.

EPC Bulletins and all other Ministry bulletins are available on the Ministry website at: http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/bulletin_mn.html.

Purpose
This bulletin addresses two topics that will be of interest primarily to general/family physicians and pediatricians. These topics are:
• A new service and fee codes for an enhanced 18-month well baby visit; and
• Payment requirements for specific fee codes associated with foot care services.

Enhanced 18-Month Well Baby Visit (A002 (GP/FP) and A268 (Pediatrics))

What is an Enhanced 18-month well baby visit?
The enhanced 18-month well baby visit is a physician assessment of a well child aged 17 to 24 months that includes all of the following:

1. Services defined as “well baby care” — a periodic assessment including complete examination with weight and measurements, and instructions to the parent(s) or patient’s representative(s) regarding health care (see page GP29 of the Schedule),
2. Completion of an 18-month age-appropriate developmental screen, and
3. Review with the patient’s parent/guardian, legal representative or other caregiver of a brief standardized tool (completed by the patient’s parent/guardian, legal representative or other caregiver) that aids the identification of children at risk of a developmental disorder.

Medical record requirements for A002 and A268
As with all services, the medical record must document that the required elements of the service have been rendered in
order for the service to be eligible for payment. A claim for A002 or A268 is only eligible for payment if the child’s medical record documents:

- The complete examination with weight and measurements and any instructions to the parent/representative;
- The 18-month age-appropriate developmental screen (i.e., Rourke or similar); and
- Any concerns identified from the review of the standardized tool with the parent/guardian, representative or caregiver.

Note: the original, or a copy of the completed screen, should be contained in the child’s medical record.

Does the “review” include counseling or discussion with respect to diagnosis and treatment options should a developmental concern be identified?
The “review” pertains to the standardized tool described in item 3 above. As with all assessments, one of the elements includes discussion with, and providing advice and information, including prescribing therapy to the patient or the patient’s representative, regarding the service (page GP15). It is understood that, when necessary, subsequent services may ensue if concerns arise based on the 18-month assessment, such as further assessments or counseling by the physician.

What is considered an appropriate 18-month developmental screen by the physician?
An example of a readily available 18-month age-appropriate developmental screen at this time is the Rourke Developmental Screen, which can be downloaded at: http://www.rourkebabyrecord.ca/rbr_ontario.html.

What is considered an appropriate standardized tool that is to be completed by the parent/guardian, legal representative or other caregiver?
An example of a readily available standardized tool for this is the Nipissing District Developmental Screen. Age-appropriate screening forms are available free of charge by ordering online at: http://www.ndds.ca/ontario/ordering.html. Physicians can direct their patients to the site and/or order their own copies from the same site. Further information about the availability of screens for various ages is available at: http://www.ndds.ca/pdf/Orderform_eng.pdf.

For payment purposes, can the Enhanced 18-month well baby visit be delegated to a non-physician, such as a nurse or nurse practitioner?
No. For payment purposes, assessments cannot be delegated to a non-physician. A002 has the same service elements as A007 (intermediate assessment/well baby care). Therefore, in order for the service to be eligible for payment, the assessment components of the service, including history, physical examination, review of the developmental screen, and discussion with the parents/representative, must be performed by the physician. Certain activities may be performed by a non-physician, such as obtaining measurements (e.g., weighing and measuring the baby).

Note: For more information on the 18-month well baby assessment, please refer to the feature article in the February 2010 Ontario Medical Review entitled “Ontario’s Enhanced 18-Month Well-Baby Visit: Program Overview, Implications for Physicians” (pp. 23-27).

Foot Care Services/Lesion Removal
The Schedule was amended in April 1, 2008, and October 1, 2009, with respect to fee codes that are frequently being inappropriately billed for certain foot care services.

Some billing concerns identified are:
- Submitting fee code Z110 for trimming/clipping of toe nails.
- Submitting surgical removal fee codes Z159 - Z161 and/or Z169 - Z171 repeatedly for same patient (e.g., ongoing weekly or biweekly claims for same patient) for foot care services.
- Delegating services to a non-physician that are not delegable, and submitting a claim for the service (Z159 - Z161, Z169 - Z171 and associated assessments).

The following provides payment eligibility information on the fee codes noted above

This service is insured when extensive debridement of an ingrown nail with removal of multiple laminae is required. Trimming or clipping of nails does not constitute the service described by Z110. Trimming or clipping of nails is not an insured service.

Z117 – “Chemical and/or cryotherapy treatment of minor skin lesions, including paring of lesions prior to chemical and/or cryotherapy treatment” (page M6 of the Schedule).

This service must include the chemical and/or cryotherapy
treatment of a lesion. While paring of the lesion is included in the service, if paring is done on its own, it does not constitute the service described by Z117. Simple paring of a lesion is not a separately listed service, and is otherwise included in the fee for the visit.

Z159 - Z161, removal of group 1 lesions (e.g., verruca, keratosis, pyogenic granuloma) by electrocoagulation and/or curetting, and Z169 - Z171, removal of group 3 lesions (plantar verruca) by electrocoagulation and/or curetting (page M2 of the Schedule).

Typically, when a service involving curetting or electrocoagulation is rendered, the clinical intent is to remove the lesion. Repeated claims for electrocoagulation or curetting on the same patient over a long period come to the attention of OHIP. Records review has shown in some circumstances that simple paring of a single lesion has occurred. Simple paring of a skin lesion does not constitute the services described by Z159 - Z161 or Z169 - Z171 for payment purposes. Simple paring of a lesion is not a separately listed service and is otherwise included in the fee for the visit.

Can these fee codes be delegated to a non-physician for payment purposes?

Fee codes Z110 and Z117 are considered procedures that may be delegated to a non-physician for payment purposes provided all of the requirements of delegated procedures are met (GP50 - GP51), including supervision and an employer-employee relationship between the physician and the non-physician. Please note that physicians are not eligible to bill for services delegated to non-physicians funded by the government (such as non-physicians employed by a Family Health Team), because the non-physicians are not considered employees of the physician(s). Physicians who receive funding from the Ministry to employ non-physicians under a funding agreement cannot bill for the services delegated to that non-physician if that funding agreement stipulates such prohibition (payment in these circumstances would result in duplication of funding).

Fee codes Z159 - Z161 and Z169 - Z171 are considered surgical procedures for which anesthesia may be required. Surgical procedures cannot be delegated (for payment purposes) and are only insured when rendered personally by the physician.

Is an assessment eligible for payment with these codes and can the assessment be delegated to a non-physician?

An assessment may be eligible for payment with these services; however, an assessment is not eligible for payment if rendered by a non-physician. An assessment is only insured if:

- performed by a physician,
- medically necessary,
- rendered in accordance with the payment requirements of the Schedule, and
- appropriately documented by the physician.

Your feedback is welcomed and appreciated!

The Education and Prevention Committee welcomes your feedback on the Bulletins in order to help ensure that these are effective educational tools. If you have comments or questions on this Bulletin, or suggestions for future Bulletin topics, etc., please submit them in writing to:

Physician Services Committee Secretariat
150 Bloor Street West, 8th Floor
Toronto, Ontario M5S 3C1
Fax: 416.340.2961
E-mail: Secretariat@pscsc.ca
Dr. Chester Brown, (Acting) Co-Chair
Dr. Larry Patrick, Co-Chair
Education and Prevention Committee

The PSC Secretariat will anonymously forward all comments/suggestions to the Co-Chairs of the EPC for review and consideration.

For specific inquiries on Schedule interpretation, please submit your questions IN WRITING to:

Health Services Branch
Physician Schedule Inquiries
370 Select Drive
P.O. Box 168
Kingston, Ontario K7M 8T4
Hospital Report Manager system links Royal Victoria Hospital with Barrie family health team

By Jennifer Liswood
OMA Public Affairs and Communications Department

Barrie’s Royal Victoria Hospital (RVH) is now electronically sending 2,500 patient reports a week to the Barrie and Community Family Health Team (BCFHT), and it has been a resounding success. “Timely access to hospital reports on my patients helps me offer better care,” says Dr. Anne DuVall, lead physician of the BCFHT. “When patients come in for follow-up care after visiting Royal Victoria Hospital, I already have received an electronic copy of their report.”

The Hospital Report Manager (HRM) system reduces strain on schedules and staff alike, as processes that used to take up to 12 days by mail or fax are reduced to half an hour. Physicians are enabled to improve their patient care delivery by having information available more quickly so they can offer more timely and proactive care, facilitated by the new technology. Medical reports, such as discharge, as well as diagnostic imaging reports are available more quickly, allowing physicians to make informed decisions and ensure that patients receive more timely follow-up care.

Other advantages of the electronic approach include the automation of manual tasks, including patient report and chart matching as well as indexing reports by types, such as mammograms. Electronic reporting also allows for multiple FHT caregivers to access patient information at the same time.

Jennifer Paradis, a Registered Nurse and BCFHT patient, says, “I have experienced first-hand how this new system can speed up access to care. After a recent trip to Royal Victoria Hospital’s Emergency on a Monday, my test results were sent back to Dr. DuVall that very same day and by the end of the week, I had a referral to another physician and a treatment plan laid out. Knowing that the wheels were in motion so quickly greatly reduced my anxiety over having to wait for results.”

The project partners include RVH, the BCFHT, OntarioMD (a subsidiary of the OMA that manages Ontario’s EMR Adoption Program), eHealth Ontario, and the North Simcoe Muskoka Local Health Integration Network. The HRM will be able to work at any hospital in Ontario to communicate with physicians using a certified EMR subsidized by Ontario’s EMR Adoption Program.

OntarioMD is currently working on the next HRM implementation phase at four additional FHTs and three hospitals. eHealth Ontario is leading the planning for the provincial rollout that will follow this initial phase of deployment.

For more information on the HRM, visit the Report Manager section of www.ontariomd.ca. Physicians can e-mail report.manager@ontariomd.com with additional questions or to indicate their interest in participating in the HRM rollout.
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In need of medical-legal advice?

OMA Legal Services can provide advice to members on the following issues relating to practice:

- general medical-legal matters
- health legislation
- group practice agreements for FHNs, FHTs, FHGs, CCMs and fee-for-service arrangements
- unincorporated associations, partnerships and practice plan development and support
- alternative funding and payment plan negotiation assistance
- advice on contracts with hospitals, universities, clinics or other institutions as employees or independent contractors
- incorporation and annual renewal for physicians
- incorporation of Family Health Teams and other physician structures

Inquiries should be directed to OMA Legal Services:

**Jim Simpson**  
Tel. 416.340.2940  
E-mail: jim.simpson@oma.org

**Robert Lee**  
Tel. 416.340.2934  
E-mail: robert.lee@oma.org

**Adam Farber**  
Tel. 416.340.2894  
E-mail: adam.farber@oma.org

**Jennifer Gold**  
Tel. 416.340.2889  
E-mail: jennifer.gold@oma.org

**tf 1.800.268.7215**  
ext. 2940, 2934, 2894 or 2889
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professional qualifications and “bedside manner”
key to finding the right fit

By OMA Insurance Services

Any of the features that define an ideal physician-patient relationship — trust, confidence, knowledge, understanding, mutual respect, and shared values — are also desirable qualities in a relationship between an insurance advisor and client. So how does one go about securing the “best possible” advisor with whom to form an insurance relationship?

Professional qualifications
With the physician-patient relationship, it is vitally important that a patient disclose all pertinent information to the physician in order to receive an accurate diagnosis and prognosis. This can only occur when there is an environment of objectivity and trust.

Similarly, an insurance advisor cannot conduct a proper needs analysis, and make appropriate insurance recommendations, unless he or she is made aware of all relevant financial and personal information.

To nurture this atmosphere of trust, insurance advisors should inform clients that they too follow a rigid code of ethics that protects confidentiality and governs the use of all client information. In addition, advisors should disclose the manner in which they are compensated so that clients can gauge the objectivity of recommendations. Some advisors are paid a commission by the insurance companies they represent, some charge a fee for service, and others receive a combination of commission plus fees.

OMA Insurance Services advisors, for example, are non-commissioned and are available to provide advice as a benefit of OMA membership.

Bedside manner
While professional qualifications and experience — in health care as in insurance matters — are critically important in ensuring an excellent professional relationship and desirable outcomes, it is clear that outcomes can also be greatly affected by the comfort level and quality of the relationship between the parties involved.

Finding an insurance advisor who is not only professionally qualified and experienced, but who also possesses a comfortable “bedside manner,” will benefit both the advisor and client in finding the best possible insurance products to suit the client’s needs.

The right insurance advisor can inspire a client to feel comfortable enough to be candid about his or her particular situation, disclose private financial details and long-term goals, ask for further explanations about recommended strategies and products, express any concerns, and ask for insurance advice whenever personal or professional circumstances change — for better or worse.

Challenges can arise when the most effective treatment a physician recommends for a patient is not the same as what the patient desires. In this case, the physician’s bedside manner may impact the patient’s willingness to listen to, and comply with, treatment recommendations and instructions. The same holds true with insurance advice — ergo the importance of a good rapport, mutual trust and respect, and shared values and perspectives to go along with solid experience and qualifications.

Research and ask questions
As with all professional relationships, it pays to do some “homework” before embarking on a plan of action.

Just as a patient would be well advised to research and ask questions prior to undergoing medical treatment or surgery, an insurance client should find out what types of policies and options are available so that he or she will be more prepared to ask relevant questions, and to have any concerns appropriately addressed prior to deciding how to proceed.

A little research can also go a long way in helping to determine whether an insurance advisor’s professional qualifications are suitable to address a client’s particular needs and long-term goals.

For assistance in finding the right insurance advisor, and the insurance products to suit your needs, contact OMA Insurance Services professionals at 1.800.268.7215, ext. 2971, or e-mail info@omainsurance.com, or visit the OMA Insurance Services website (http://www.omainsurance.com).

Your trusted OMA Insurance advisors are qualified to diagnose your insurance needs and present a suitable insurance solution.
Onglyza is indicated in patients with type 2 diabetes mellitus to improve glycemic control in combination with metformin or a sulfonylurea, when metformin or the sulfonylurea used alone, with diet and exercise, does not provide adequate glycemic control.\(^1\)

Onglyza is not recommended in patients with moderate to severe renal impairment, including patients with end stage renal disease requiring hemodialysis. Onglyza is not recommended in patients with moderate to severe hepatic impairment. Onglyza is not recommended in patients with congestive heart failure. Onglyza is not recommended for use by women who are pregnant, and should not be used by women who are nursing. Onglyza should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. Onglyza should not be used in pediatric patients (<18 years of age).\(^1\)

Onglyza is contraindicated in patients who have had a history of any serious hypersensitivity to this drug or any ingredient in the formulation or to another DPP-4 inhibitor.\(^1\)

In a clinical study that combined Onglyza with metformin, the most commonly reported adverse events, regardless of causality and more common with Onglyza than placebo, were nasopharyngitis (11.0% vs. 10.6%) and bronchitis (9.4% vs. 6.1%).\(^1\)
In a clinical study that combined Onglyza with a sulfonylurea (glyburide), the most commonly reported adverse events, regardless of causality and more common with Onglyza than placebo, were hypoglycemia (19.8% vs. 18.4%) and urinary tract infection (13.8% vs. 10.9%).

Please consult prescribing information for warnings, precautions and adverse events.

The idea that patients should be at the centre of the health-care system has become a topical issue. In many systems today, including Ontario’s, health care is not patient-centred. Rather, the patient is required to adapt to the system and to navigate through its many intersections. Patient-centred care has been identified as an important problem by organizations around the world, including the World Health Organization (WHO),1 the Organization for Economic Co-operation and Development (OECD), the National Health Service in Britain,2 the National Health and Hospitals Reform Commission in Australia,3 and the Commonwealth Fund Commission,4 and American Agency for Healthcare Research and Quality (AHRQ) in the United States.5

In this paper, patient-centred care research is reviewed from both the system standpoint and the practitioner standpoint, including research and experience in other jurisdictions, and challenges to providing patient-centred care. OMA “Policy Recommendations for System Change” are presented, along with “Principles of Patient-Centred Care for Physicians,” on pages 43 and 44 respectively.

What Constitutes Patient-Centred Care?
Patient-centred care is a somewhat tenuous concept. In some systems, it seems to encompass all that is synonymous with good care and good communication. With such broad definitions, any care element considered desirable could be called patient-centred. The OMA definition of patient-centred care is as follows:

“A patient-centred care system is one where patients can move freely along a care pathway without regard to which physician, other health-care provider, institution or community resource they need at that moment in time. The system is one that considers the individual needs of patients and treats them with respect and dignity.”

Regardless of the specific definition, patients will vary in the extent to which they desire and are able to participate in decision-making. Moreover, the same patient may want to participate fully in some situations, but in others prefer to rely upon the physician’s advice entirely.

From the physician’s perspective, the propensity to be patient-centred will vary with knowledge of the patient. Both the attitudes and the behaviours of physicians and other health-care providers will determine whether care is centred on patients.

Although the two concepts are not entirely separate, patient-centred care can be addressed from both a systemic level and from the perspective of physicians and other health-care professionals.

PATIENT-CENTRED CARE: SYSTEM LEVEL
Challenges to patient-centred care at the system level include integration and access. Funding is also a factor that will be addressed later in the paper.
Integration
For a system to be truly patient-centred, care must be integrated across the system. This problem of lack of integration has been recognized as one of the most difficult challenges facing the Ontario health-care system. When a patient moves from one part of the system to another—from hospital to home or to another facility, from home to long-term care, from long-term care to hospital, or from general practitioner to specialist—our system often fails the patient. It is built with individual system components, rather than with the patient as the centre of a pathway that moves easily through intersections from one part of the system to another. Patients with comorbidities, those with high-risk conditions, and the frail elderly are most vulnerable. We are not alone in facing this challenge. The OECD has recently undertaken a survey to gather information on care co-ordination concerns, problems, and practices among OECD and European Union (EU) countries. Twenty-six countries responded. The OECD report suggests that care co-ordination problems are worst at the interfaces between health-care sectors and between providers.

The OECD report indicates that most policies directed toward system change share the intent of reducing the need for high-cost hospitalization for the chronically ill by shifting the locus of policy attention and program toward ensuring high-quality, patient-centred care outside of acute hospital settings. They suggest that disease and case management programs seem to improve quality, but that their cost-effectiveness is inconclusive and that better information transfer between parts of the system could be achieved by electronic medical records. Multidisciplinary teams are proposed as a better method of ensuring care co-ordination than the solo family practitioner. This is in concert with the OMA’s Policy on Interprofessional Care, which states that the collaboration that occurs in interprofessional team care is built with individual system components, rather than with the patient as the centre of a pathway that moves easily through intersections from one part of the system to another. Patients with comorbidities, those with high-risk conditions, and the frail elderly are most vulnerable. We are not alone in facing this challenge. The OECD has recently undertaken a survey to gather information on care co-ordination concerns, problems, and practices among OECD and European Union (EU) countries. Twenty-six countries responded. The OECD report suggests that care co-ordination problems are worst at the interfaces between health-care sectors and between providers.

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Access
Another key problem is that for the health-care system to function effectively, the system needs to match demand to capacity, and do so with minimal delay. When demand exceeds capacity at any point in the system, there will be delay and a bog in the system. This is a tremendous impediment to access in Ontario, and one of the main reasons that the system fails patients.

Some populations have more difficulty accessing the system than do others. Those who are educated and health literate are more able to negotiate and navigate the system. The less educated, the frail elderly, those for whom English is not a first language, and those with mental illness or substance use problems have more difficulty.

At the practitioner level, problems with patient accessibility to physicians include such matters as quick access to appointments for sick patients, telephone or e-mail access, and office hours that extend beyond the 9:00 to 5:00 weekday. Many physicians are already overworked, and there are continuing demands to increase availability and take on more patients. Both patients and physicians see access as problematic. In a survey of Canadian households commissioned by the Canadian Medical Association, respondents gave an overall score of 5.63 of a possible 10 to the extent to which health care in their community is patient-centred, with the lowest scores for waiting after arrival for health-care appointments and for wait times for appointments to see specialists. In a survey of 11 countries, only 43% of Canadian primary care physicians reported after-hours arrangements to see a physician or nurse without going to the ER. This rating was 10th among 11 countries. With regard to perceptions of access to specialists, 75% of Canadian primary care physicians surveyed reported that patients often faced long waiting times. Canada tied for last place.

Compared to other countries, Canada also rates poorly in comparisons of time for sicker adults to see a physician. In same-day service or next-day service for these patients, Canada rated 6th of 6 countries, including the U.S., with just 36% able to access care the same day or the next day, compared to 81% of New Zealanders. Thirty-six per cent waited six days or more. Canada also fared poorly comparatively with access to care on nights, weekends, and holidays without going to the emergency room. Over half of Canadian adults surveyed reported getting care “very” or “somewhat” difficult at such times.

The concept of advanced access to primary care has come to the fore as systems have examined ways to make primary care more accessible, some on a 24/7 basis, and some by reducing the delays for patient appointments and permitting same-day service.

The American Institute for Healthcare Improvement (IHI) has a model for improvement that has been specifically adapted to improving primary care access. It suggests three strategies for improving patient access are: increasing the ability of the system to predict and absorb demand; matching supply and demand; and, redesigning the system by making it more efficient. In terms of process, IHI suggests a “plan, do, study, act” cycle for testing a change in the work setting by planning it, trying it, observing results, and acting on what is learned. Although it seems that these strategies may also be useful for specialty care, IHI has a specific website for specialty care that provides examples of systems where access to various types of specialties has been improved.

Canadian and International Research and Experience
Some jurisdictions have just begun to organize their health-care systems around the patient, identifying this as a principle to be achieved, whereas other jurisdictions seem to have already embraced and implemented this concept. Examination of Canadian and international experience at the practitioner level often includes the dimension of accessibility to physicians. In Britain, the goal is fast access to reliable health services, the
Dutch use the concept of responsiveness, and Health First Europe asserts that care for patients should include access to health-care services warranted by their condition.

**Ontario**

Ontario has implemented a variety of funding models in the last decade that vary somewhat in terms of services to patients and incentives to physicians. But all of these new models require comprehensive care and provide extended access to patients. There has not yet been a published evaluation.

Telehealth Ontario is a service designed to provide health advice or information on a 24/7 basis. It is staffed by nurses who will assess the situation and recommend a visit to a clinic, physician, hospital, or other community resource, as the situation warrants.

A variety of other initiatives have been undertaken over the past five years or so with a goal of improving patient transitions from one part of the system to another, and addressing the disparity between supply and demand. These include Ministry of Health and Long-Term Care (MOHLTC) initiatives such as the Wait Times Strategy, the Aging at Home Strategy, and the Critical Care Strategy. These initiatives are laudable; whether they will change the system has yet to be determined.

The MOHLTC has strategies in place to reduce wait times for surgical procedures and in hospital emergency rooms. This is one way of addressing demand exceeding the capacity of the system. Wait time information is transparent and available online for ERs and for current surgical and diagnostic imaging procedures. Results are generally positive. Surgical and diagnostic imaging wait time information is collected and posted for general, heart, ophthalmic, orthopedic, and pediatric surgery, and for MRIs and CT scans. Except for bypass surgery, they show significant reductions in all major categories. Although there has been no overall change since 2008 in emergency room wait times, results for patients with more complex conditions in ERs have been reduced significantly.

More recently, the MOHLTC, in collaboration with the Collaborative for Health Sector Strategy of the Rotman School of Management, and the Ontario Association of Community Care Access Centres, has embarked on an integrated client care project. It is intended to be a multi-year, multi-project initiative, with the first project to deliver patient-centred wound care for people receiving home-care services.

**Canada**

Patient-centred care is a focus in other provinces, including British Columbia, Alberta, Saskatchewan, and New Brunswick. The Calgary Health Region is evaluating several strategies to improve system integration, including creation of a central access and triage system, prioritization tools for specialty access, and redesign of clinic process flow to reduce wait times.

**International**

In the past decade or so, the U.S. Veterans Administration (VA) has transformed itself. Patient-centred care co-ordination is organized so that the patient is the locus of control and the provision of care is seamless across environments. The VA uses technology to support patients’ ability to successfully age and manage disease in their own home. It has identified care co-ordination and supportive technologies as its preferred mechanisms to preserve independence and postpone or alleviate the need for institutional care for those who are frail from chronic illness or advanced age. Since 1996, improved outcomes have been achieved in all dimensions, while reducing the cost per patient by more than 25%. The VA achieved this by the use of evidence-based practices, proactive approaches to patient safety, and use of advanced technologies, such as electronic health records and bar-coded medication administration. Structurally, it has been transformed from a hospital system to a health-care system, with co-ordination among facilities and resources. Financial incentives were provided for co-ordination of care and resources among previously competing facilities. The VA measures both performance and value on multiple dimensions.

Patient care in Denmark is considered to be highly accessible, while enjoying low total health-care expenditures. A system has been developed so that, in every county, clinics see patients at nights and weekends. Weekend physicians take telephone calls from patients and can readily access their electronic records; they can prescribe medications electronically, or ask patients to come in to see them. They are paid a higher fee for telephone consultation than visits. The patient’s own primary care physician receives an e-mail the next day with a record of the consultation. All (98%) of primary care physicians are required to have an electronic medical record. The easy accessibility of physician advice by telephone or e-mail, and electronic systems for prescriptions and refills, reduces both physician time and patient time.

Health First Europe is comprised of 24 member organizations that represent patients, health-care workers, academics, policy-makers and medical industry experts, and is supported by 19 members of the European parliament. Its recent report exploring approaches to health care in the coming decades contains an essay defining principles on patient-centred care. These principles have some appeal in that they incorporate the notion of the partnership between patient, family, and physician; patient responsibility for health care and involvement in decision-making; and information provided to enable informed choices. Most importantly, the principles assert that patients should be involved at their level of choice. This will vary from patient to patient and situation to situation.

Both Australia and Holland have also focused on patient-centred care, with the Dutch equating patient-centred care with responsiveness.
The Concept of the Medical Home

The “medical home” is much in vogue, particularly in the United States. Here in Canada, The College of Family Physicians of Canada recently issued a discussion paper on the concept of the medical home. In the U.S., several associations — the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, have jointly developed principles of the patient-centred medical home. They are summarized as follows:

- Personal physician: each patient has an ongoing relationship with a personal physician who provides first contact, continuous and comprehensive care.
- Physician-directed medical practice: the physician leads a team who care for patients collectively.
- Whole person orientation: the personal physician is responsible for providing or arranging for care at all stages of life — acute care, chronic care, preventive services, and end of life care.
- Care is co-ordinated and/or integrated across all elements of the health-care system, such as specialty care, hospitals, home health agencies, nursing homes, and the community. Care is facilitated by registries, information technology, and other information exchange.
- Quality and safety, including patient-centred outcomes, evidence-based medicine with clinical decision support tools, physician accountability, patient participation in decision-making, information technology, government recognition process, and patient participation in quality improvement.
- Enhanced access through open scheduling, expanded hours, and other communication options.
- A payment structure that recognizes the added value provided to patients with a patient-centred medical home.

In 2006, the American Academy of Family Physicians launched the National Demonstration Project to test a model of the patient-centred medical home (PCMH) in 36 family practices. After three years, the evaluators have raised concerns about the Demonstration Project. In particular, they indicate that transformation to a PCMH requires epic whole-practice reimagination and redesign. It is not an incremental process. Because the components are interdependent, they represent a gestalt that cannot be broken into easily reconfigured pieces or put together in a temporal fashion. The evaluators assert that transformation requires new scheduling and access arrangements, new co-ordination arrangements with other parts of the health-care system, group visits, new ways of using evidence, quality improvement activities, more point-of-care services, development of team-based care, changes in practice management, new strategies for patient engagement, and multiple new uses of information systems and technology.

Their analysis indicated that the current designs seriously underestimate the magnitude and timeframe for the required changes, overestimate the readiness and expectations of information technology, and are seriously undercapitalized. The PCMH requires different skills for most family practitioners. Physicians needed facilitative leadership skills, the ability to work in practice teams, manage chronic care using the chronic care model, use evidence-based medicine, integrate change management, and partner with patients. Change fatigue was a serious problem, even in highly motivated practices.

Another evaluation was done in Seattle, where a patient-centred medical home concept was evaluated over a one-year period. The results were more positive than the National Demonstration Project, but to achieve these results, physician panels were reduced to 1,800 patients, visit time was expanded from 20 to 30 minutes, “desktop medicine” time was allocated daily, staffing was increased for physicians (15%), physician assistants (44%), registered nurses (17%), medical assistants (18%), and clinical pharmacists (72%).

Apart from whether one adopts the medical home model, much of patient-centred care research and policy is directed toward the relationship between the patient and the general practitioner. However, the patient has other relationships with other types of physicians — specialists of one sort or another — and in other parts of the system, such as hospitals and long-term care facilities. Changing just one part of the system would not be a panacea.

INDIVIDUAL PRACTITIONER CARE

Although Ontario physicians are patient-centred in as much as they focus their care on the needs of the patient before them, the literature on patient-centred care abounds with information about the critical elements of this concept. Such information may be useful to physicians in refining their own interactions with patients and improving their patients’ interactions with the system. Two elements of patient-centred care at the practitioner level are common in the literature: effective communication between physician and patient, and a shared decision-making process. For the physician, effective communication includes an understanding of the patient’s life and how that contributes to their health, and clear explanation to the patient of the issues. Effective communication also entails showing respect for the patient. The shared decision-making process between patient and physician relates to decisions about treatment, given options, and about ongoing management of health problems. It assumes that both the physician and the patient bring valuable information. The physician brings information about the illness, treatment options, risks, benefits and evidence. The patient brings information about values, treatment preferences, and treatment goals. The decision-making process occurs in physicians’ offices and in other parts of the healthcare system, such as hospitals and long-term care facilities.

Communication with Patients

Communication with patients is perhaps most critical for the physician. However, communication problems occur...
between patients and other health-care providers, and they occur across the system, not just in the physician’s office. Showing respect for the patient is a key component of patient-centred care. Some information, such as communicating risk, is particularly difficult, and is exacerbated by poor health literacy. Patients with mental health or substance abuse illnesses, patients who are very ill, and pediatric patients present particular challenges to the physician and the health-care team in physician offices, in hospitals, and in other care facilities. Depersonalizing patients is a risk across the system, perhaps worse in acute care situations.

Respect for the Patient
In an American study examining whether patients feel respected in their physician’s office,26 about 3,500 adults responded to a survey about their feelings as to whether they were shown respect by their physicians. Questions were on a four-point semantic differential scale. Results showed that minorities and those for whom English was a not a first language were more likely to report that their doctor did not treat them respectfully, or looked down on the way they lived their lives. They believed they would have gotten better medical care if they belonged to a different race or ethnic group. Overall, 29% of Asians, 22% of Hispanics, and 19% of African Americans reported being treated with disrespect, compared to 13% of white Americans. Patients who had these feelings were more likely to report not following the physician’s advice and delaying needed care. Both the patients’ feelings of being treated disrespectfully, and their subsequent health behaviours, are of concern. Undoubtedly, the American experience of health care is different from the Ontario experience, however, there are indications that Canadian health-care providers could improve somewhat in ensuring that their patients feel respected.

In a survey of Canadian households commissioned by the Canadian Medical Association,27 respondents gave an average score of 7.45 on a scale of 0 to 10 to the validity of a statement that they are treated with respect and dignity by health-care providers. It is not a bad score, but there is room for improvement. Respect for patients is a key dimension of patient-centred care.

Depersonalizing Patients
At all stages of the system, the capacity of physicians and other health-care professionals to respond to patients as individuals is at risk. There is an inherent conflict between the ability to cope daily with strangers who are partly dressed, sick, suffering, in pain, or dying, and the ability to remain sensitive to these individuals as people. The natural human defence in such situations is to depersonalize people in distress so that the health-care professionals can continue to cope. This creates practices that protect health-care professionals, but are insensitive to patients. From the patient’s perspective, events that are unique, profoundly important, and personal are transformed into matters of routine, and patients become one of “this group of patients,” “this type of problem,” or “this procedure.” Depersonalization is probably more prevalent at acute care settings where patients are sicker, but all care settings have the potential to depersonalize patients.28

Health Literacy
Patient health literacy impacts patients at all points in the health-care system—in accessing services, in the physician’s office, in hospitals, and in other care facilities. Health literacy is one of the challenges to patient-centred care. Patients who are not health literate will experience difficulty accessing preventive care, have poorer understanding of their conditions and care, higher use of health services, lower adherence to medication, and less participation in decision-making.29 In addition to poor document comprehension and deficient problem-solving skills, many patients have inadequate numeracy skills; thus, communicating risk in quantitative terms may be problematic.

The OMA recently released a background paper entitled, “Patient Health Literacy: Implications for Physician Practice and Health System Planning,” which contains information about how to assess patients’ comprehension and ensure that patients understand disease concepts and participate in decisions about treatment. Ensuring that patients comprehend information can also increase the likelihood that they are compliant with medication instructions. The paper is available on the OMA website at: https://www.oma.org/Resources/Documents/2009OMAHealthLiteracyImplications.pdf.

Communicating Risk
Many illnesses require the participation of the patient in making decisions about treatment options. Decisions about treatment for life-threatening illnesses are perhaps most difficult. A Canadian study done with relatively well-educated participants from southern Ontario was designed to test the ability of older Canadians (age 50 to 90) to understand Internet-based information about cancer risk and prevention, presented in paper form.30 The best predictors of scores were age and tests of numeracy skill, including ability to discern differences in the magnitude of health risks, and use percentages and proportions.

Patients with Mental Health Illnesses
Involving patients with mental health illnesses in decision-making is challenging for both the general practitioner and the psychiatrist. There is a paucity of research on this dimension of shared decision-making. Research from the U.S.,31 the United Kingdom,32 Germany,33 and Italy34 indicates that neither general practitioners (U.S., U.K., and Germany) nor psychiatrists (Italy) tend to involve patients with depression or other mental health illnesses in shared decision-making. There is some indication that when depressed patients are involved in decision-making in the primary care setting, their depression outcome is better.35-9 Results indicated that, with every 1-point increase in decision-making ratings, the prob-
ability of depression resolution increased 2%-3%, and the probability of the patients receiving guideline-concordant care increased 4%-5%.

The evidence suggests that poor decision-making is better predicted by cognitive impairment than by psychotic symptoms.36 For those whose decision-making is impaired, there are adaptations that the physician can make to improve the patient’s decision-making ability. The goal is to help the patient explore the medical and personal concerns with a minimum of defensiveness or distortion. Ness suggests two techniques: exploration to understand the patient’s view and to assess for possible skewing of judgment, and counterbalancing to redress the biased judgment by educating and advocating for a more neutral position. These processes may alternate. The optimal result is to expand the patient’s freedom to make decisions and promote the best fit between the patient’s views and physician’s views toward treatment decisions.37

Patients with Substance Abuse Illnesses
Like those with mental health illnesses, patients with substance abuse illnesses face discrimination and bias. They are often marginalized and disenfranchised from society. Such patients are also often treated with disrespect, as if the diagnosis of addiction is some sort of moral flaw. American evidence suggests that the public view of those with substance abuse problems is that they are incompetent in decision-making and dangerous.38 In a non-intoxicated state, there are fewer concerns about decision-making ability than for those with mental illnesses. However, substance dependence is characterized by compulsive drug-taking behaviours, even when the patient is faced with serious adverse consequences. The result of this is that there is great variability in decision-making ability among patients with substance-abuse illnesses, with some patients performing as well as normal comparison subjects.

Pediatric Patients
Pediatric patients are dependent upon their families, so for these patients, patient-centred care is better conceptualized as family-centred care. As with patients with mental health illnesses, there is little research available. In 2009, a Cochrane review from 1966 to 2004 found no studies that met inclusion criteria to permit a review of the effects of family-centred models of care for hospitalized children when compared to standard or professionally-centred models on child, family, and health service outcomes. They conclude that research, using factors that can be measured, is needed to assess whether family-centred care improves a child’s experience of hospitalization.39

Several hospitals have reported that parental involvement in rounds has been a positive experience. In a large academic children’s hospital in Seattle, participation in rounds was important to parents because it increased their ability to communicate, understand the plan, and participate with the team in decision-making about their child.40 Similarly, the Cincinnati Children’s Hospital found that family involvement in rounds seemed to improve communication, and that it shared decision-making. It also offered new learning for residents and students.41

The Decision Process
One of the basic tenets of patient-centred care is that patients participate in the decision-making process about their treatment options, to the extent that they are able and willing to do so. The process may be shared; the decision resides with the patient. Informed consent is a basic premise in law.

To engage patients in the decision-making process, physicians need information about how people make decisions and the sorts of influences that will affect their decision-making processes. In the section below, some of these influences are discussed. As well, the type of decision being made will have an impact on decision-making for both physicians and patients.

Informed Consent
Under the Health Care Consent Act, 1996, physicians are required to obtain consent for treatment that is informed, given voluntarily, related to the treatment, and not obtained through misrepresentation or fraud. Such treatment is informed if the person receives information about the nature of the treatment, the expected benefits, the material risks, the material side-effects, alternative courses of action, and the likely consequences of not having the treatment. Moreover, the person must receive responses to his or her requests for additional information about those matters.

The courts have long recognized a capable patient’s right to make autonomous decisions. The right to make what physicians may consider “bad decisions” flows directly from the court-recognized right to patient autonomy. This concept of patient autonomy is a fundamental element of not only our common law on consent, but also our legislative framework under the Health Care Consent Act, Substitute Decisions Act, and the Mental Health Act.

By law, except in emergency situations where an override is possible, the physician proposes a treatment, explains the risks, benefits and alternatives, and the patient consents or refuses. In practice, patients rely heavily on the expertise of physicians, but at law it is always the patient’s decision.

Patient Health Literacy and Risk Level of Decision
The desire of patients to participate in the decision-making process will vary depending on the risk implications of the decision and the level of health literacy of the patient. If the patient’s level of health literacy is low, it is likely that reliance on physician expert input will always be high, regardless of the level of the risk of the decision. In contrast, if the patient’s health literacy is high, it is more likely that the patient’s desire for physician expertise will vary depending on the importance of the decision. When faced with an acute illness requiring immediate treatment, patients will usually rely on the expertise of their physician, regardless of their health literacy.
Patient Personality, Education, and Experience

Personality, education, and experience also influence the degree of participation that patients want in the decision-making process. Generally, baby boomers are more likely to want to be engaged in the decision-making process than their parents’ generation. Moreover, generation Y, the children of the baby boomers, not only want involvement; indeed they will demand it. This is, of course, a broad generalization — there will be variability among the generations depending on the individual patient’s intelligence, education, experience, and personality.

Different types of patients value different attributes of patient-centred care. Using statistical methodology that permits analysis of multiple combinations rather than just single preferences, Ontario researchers have found that patients and their families can be categorized into two broad groups: an informed group and a convenience group. The informed group values the opportunity to learn health improvement skills, teamwork and interprofessional communication, and brief waiting times. In contrast, the convenience group values convenient settings, a welcoming environment, and ease of both internal and external hospital access. Demographic differences showed that participants in the informed care segment were significantly more likely to have higher education.

Patient Self-Management of Chronic Conditions

Although there are no accepted defining criteria, most patient-centred care models include the idea that the patient and the physician share management of health problems, and that patients self-manage some aspects of their condition, particularly chronic conditions. Here, the goal is supporting a wide range of people in living well with chronic conditions.

The OMA’s Policy on Chronic Disease Management provides information about the prevalence of chronic conditions in Ontario, the effectiveness of Ontario’s current chronic disease management, and models of chronic disease management and their implementation in Canada and internationally. It also contains OMA policy recommendations regarding chronic disease management. The policy is available on the OMA website at: https://www.oma.org/Resources/Documents/2009ChronicDiseaseManagement.pdf.

Framing Effects

Contrary to popular opinion, people do not make logical decisions in situations involving risk. It turns out that their decisions have biases that can be determined experimentally. Prospect theory, the leading model of decision-making to explain these biases, was developed by psychologists Daniel Kahneman and Amos Tversky. One of those biases depends on how risks are framed. The idea is that people will make different decisions depending on whether the same choice is framed positively or negatively. This has implications for physicians when they are explaining to patients the risks and benefits of particular drugs or drug combinations, or the potential outcomes of treatment options. In hundreds of experiments over decades, Kahneman and Tversky and their colleagues have found that responses to a choice framed negatively (as 1 in 100 people will be affected by this drug) or positively (not affecting 99 of 100 people) will differ. People overwhelmingly prefer the latter choice, a positive frame, even though they are logically equivalent. Similarly, people will prefer a procedure in which 75% of people live to one in which 25% die, despite their equivalence. These experimental outcomes hold with a variety of participants, including those who are statistically sophisticated, the young and old. Effects are exacerbated by affect, such as will occur when patients are stressed.

What should physicians do? The best option is to provide the information in both positive and negative frames. Thus, when explaining side-effects of medication, the best strategy is to indicate that among 100 people, 99 will not be affected and 1 will. Similarly, when discussing treatment outcomes, indicate both the positive and negative outcomes for each choice.

Decisions at the End of Life

Decisions about end-of-life care for adults and for the families of children and neonates are difficult for both patients and physicians. Physicians are trained to prolong life, but in some situations prolonging life may be the wrong choice. Not having conversations about patients’ desires and wishes is consequential for patients, for physicians, and for the health-care system. In the absence of informed shared decisions that are responsive to the needs and values of individual patients, interventions may be provided to patients who would not choose them, and withheld from those who would.

These situations are often anguishing for families. It is during such times that they most need good communication and interaction with physicians and other members of the health-care team so that they can be informed and participate in the decisions that need to be made.

Communication with Patients and Families in the Intensive Care Unit (ICU) and Emergency Department (ED)

The American College of Critical Care Medicine Task Force has developed clinical practice guidelines for support of the patient and family for adult, neonatal, and pediatric patient-centred care in the ICU. The Task Force did an extensive review of the literature, much of which it found to be of a low level (Cochrane 4 or 5) or non-existent. The guidelines were developed and debated until consensus was achieved. The Task Force made 43 recommendations, all of which will not be reiterated here. They included:

- Endorsement of a shared decision-making model.
- Early and repeated care conferencing to reduce family stress and improve consistency in communication.
- Honouring culturally appropriate requests for truth-telling and informed refusal.
- Spiritual support.
- Family presence at both rounds and resuscitation.
- Open flexible visitation.
- Family support before, during, and after a death.
Patient-Centred Care

With regard to the latter point, interventions to support bereaved families, particularly families of pediatric patients, have been found to be ineffective, sometimes intrusive, and unwarranted. The consensus seems to be that any interventions undertaken should target only high-risk caregivers and mourners who are highly distressed or depressed.50

Similar guidelines have been developed for family member presence for pediatric patients in emergency rooms. The recommendations are that, if they wish, family members should be permitted to be present during procedures and resuscitation attempts.51,52

**EFFECT OF PATIENT-CENTRED CARE ON OUTCOMES**

Patient-centred care is a difficult concept to measure because it is multifaceted and, at its heart, it is a dialogue between two people with differing personalities, perspectives, and attributes. Thus, the process itself is hard to measure.53 Moreover, as will be seen from the studies below, not all physicians or patients are willing to have data collected, and those giving consent to participate in studies may differ from those who do not. For those who do participate in studies, both patient and physician will modify their behaviour when they are being observed. These problems are faced commonly in any measures of human interaction.

The particular measures used are factors to consider — some may be more valid indices of patient-centred care than others. Patient satisfaction is a common measure. However, the British system has chosen to measure patient experience, not patient satisfaction. The Picker Institute argues that patient experience surveys are more useful in describing encounters with service, and a more valid measure of progress. Like Canadians, many British patients report overall satisfaction with their health care, but experience surveys can reveal areas that would benefit from attention, as well as those that are working well. Typically, satisfaction results do not provide useful information for system improvement.

Physician behaviours that improve patient satisfaction may be distinct from those that improve health outcomes, thus when patient satisfaction is used as the measure, patient-centred care may be rated highly, but health outcomes poor.54

There is some preliminary research that supports this distinction. In an analysis of studies of health-care communication with patients with chronic illness, researchers found that they could distinguish two aspects of patient-centred care: the ability to elicit and discuss patients’ beliefs, and the ability to activate patients to take control in the consultation or in the management of their illness. Preliminary results indicate that the former leads to improved patient satisfaction, but that to improve health outcomes, the ability to activate the patient is needed.55

Is it important that patient-centred care affects health outcomes positively? The consequential view maintains that actions are morally right to the extent that they lead to desirable consequences. Thus, if it could be shown that patient-centredness improved patient outcomes, by this view it would be desirable. However, it may be that patient-centredness is intrinsically important, regardless of whether it impacts health outcomes positively.56 Results of the research relating the effects of patient-centred care on outcomes is conflicting and often methodologically weak, so there is not strong evidence that patient-centred care affects health outcomes positively, as indicated below.

In an excellent evaluation of the relationships between patient-centredness, outcomes, and cost in a hospital situation, researchers found that hospital units that were more patient-centred had statistically significantly better outcomes, but higher costs than those that were less patient-centred.57 An American review of 23 studies examined whether fulfillment of patients’ expectations about their primary care visit affected their satisfaction with the visit. Results indicated that, in about half of the studies, addressing patients’ expectations positively influenced their satisfaction. Similarly, fulfillment of patients’ expectations influenced other outcomes, such as symptom improvement or disease control, in three of five studies. Results regarding outcomes of prescription compliance or health status were also ambivalent. In the United Kingdom, a comprehensive review of published research between 1969 and 2000 yielded only nine papers that met inclusion criteria. The authors concluded that the evidence that patient-centred consulting leads to better outcomes in primary care is ambiguous.59

**BARRIERS TO A PATIENT-CENTRED CARE SYSTEM IN ONTARIO**

Ontario’s health-care system is a large, lumbering giant that needs fundamental reform. It was developed in the 1960s, and has served us well for decades. Now, service demand exceeds the capacity of the system, causing bottlenecks. Because of its size and complexity, intervening at any one part of the system tends to move the bottleneck from one part to another, without resolving the fundamental problems. To change the system, we will need to address institutional funding, integration and co-ordination of care, and service demand exceeding supply.

**Institutional Funding**

One of the advantages and disadvantages of the American system of institutions is that it is competitive. Ownership is not entirely by the state, and there is sufficient redundancy in the system that patients have choice. The competitive nature of the institutional system has led to some innovative and patient-centred programs. However, the American system is also much more inequitable than our system, such that those who are better educated and wealthier can access services more easily. The principle of universal health care, such as we have in Canada, is not a recognized right in the U.S.; the result is that for many Americans, the cost of services is the determining factor.
In Ontario, current funding models are one of the main deterrents to efficient and integrated services for hospitals and other health-care institutions.

Hospitals
Operational funding for Ontario hospitals occurs through the Local Health Integration Networks (LHINs) and is on a global basis; that is, hospitals receive a global budget for their operational costs. Hospitals have service accountability agreements with the LHINs. The result of this type of funding is that there are few incentives for hospitals to work together or with other health-care organizations to improve efficiencies or to provide more integrated services. This contrasts with the system developed by the U.S. Veterans Administration, which provides financial incentives for co-ordination of care and resources among facilities. There is also a lack of knowledge about cost break-downs in our hospital system. The Kirby Commission reported that, within hospitals, costs of individual procedures, even those such as simple appendectomies, are often unknown with the present funding model.60

Within hospitals, savings in one department do not translate to other departments. This is exemplified in the LHIN Hospital Service Accountability Agreements, which provide the formula for "total margin." Total margin is the per cent by which total revenues exceed or fall short of total expenses, in a given year. The formula specifies that interdepartmental recoveries and expenses are excluded in both the numerator and denominator of the formula.61

In 2002, the Kirby report61 recommended that the global method used for remunerating hospital funding should be replaced by service-based funding.61 More recently, the same recommendation has been made in a report published jointly by the Ontario Hospital Association (OHA), Ontario Association of Community Care Access Centres (OACCAC), Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP), Ontario Association of Non-Profit Homes and Services for Seniors, and Ontario Long-Term Care Association.62

Funding for other Institutional Health Service Providers
Although funding for other institutional health service providers differs from hospital funding, they suffer from some of the same problems of lack of co-ordination and efficiencies. Long-term care funding is a mix of across-the-board funding increases and allocations based on an equity funding formula. The community mental health and addictions funding is based on transfer payment agreements between the Ministry of Health and Long-Term Care and service providers for specific programs. In the future, LHINs will determine each service provider’s funding allocations where otherwise not specified in the Ministry/LHIN Accountability Agreement. This could cause increased variability across the province. The recent report cited above of the OHA, OACCAC, OFCMHAP, and others suggests a service-based funding system for operational funding to all providers funded through LHINs.

Demand and Supply
A 2006 report of the Physician Hospital Care Committee63 informs that the number of acute care beds in Ontario declined by 22% during the mid to late-1990s, and that occupancy rates have remained consistently well above 90% since 2000. There is no redundancy in the system. The report suggests that the obstacles inhibiting patient flow through the health-care system occur at both ends of the hospital experience: a lack of inpatient beds, and a lack of integration between hospital and community. The result is overcrowding in the emergency room, and patients occupying acute care beds who are ready to be discharged. There are multiple causal factors: emergency room assessment and disposition is slow; moving patients from either the emergency room or from acute care beds to alternative levels of care settings is problematic because of inefficiencies in planning and lack of community resources. Waits to get from hospital to long-term care are an impediment to efficient use of hospital resources. In the last quarter of 2007/2008, the median number of days to long-term care from acute care was 50.64 Undoubtedly, some of these patients will be difficult to place. Canada-wide, 24% of alternative levels of care days are for patients who have dementia as a comorbidity; another 10% have dementia as their main diagnosis.65

A comparison of the American Kaiser Permanente system with the British National Health System revealed startling differences in per capita acute bed days. The NHS had a rate of 1,000 per 1,000 population per year compared to the Kaiser Permanente rate of almost one-quarter that (270 per 1,000 population per year). Key differences are that Kaiser Permanente focuses attention and resources on monitoring admissions, reducing lengths of stay, creating disease management programs for chronic conditions, and opening physicians’ offices in the evenings and weekends to reduce the use of hospital emergency rooms for non-emergency care. Because of reduced hospital costs, Kaiser has many more specialists per capita, particularly in those areas needed for those with chronic diseases. Kaiser also exists in a highly competitive market. Per capita costs of the two systems are similar.66

Ontario physicians report that demand exceeds resources not just for primary and specialty physician care, but for community programs to help patients with chronic diseases manage, such as programs for patients who have pulmonary illnesses or are diabetic. Community programs to assist the elderly to remain at home, and to help those leaving institutional care, are also insufficient. Palliative care programs are not easily accessible to all who would benefit.

The Canadian Medical Association commissioned a survey of public views on the health-care system from about 1,000 Canadian households.67 More than half of respondents indicated that they have to have the same medical tests repeated simply because they are seeing different medical professionals; that they have to repeat their health history each time they encounter a different health-care provider; and that they have...
Policy Recommendations for System Change

- The OMA believes that patient-centred care provides benefits to patients and the health-care system beyond its effect on health outcomes or system costs. To this end, it will strive to join together with other stakeholders in the health-care system to transform the system to one that is centred on the patient. It commends those organizations that have begun this process.

- The Ministry of Health and Long-Term Care should be accountable for ensuring that hospitals and other health-care institutions are patient-centred. Results of patient-centred policies and activities should be assessed on the basis of evidence and made public, including results of both patient outcomes and patient experience.

- The OMA encourages the Ministry of Health and Long-Term Care and other health-system stakeholders to continue to expand transparency in the system, such as is exemplified by online posting and publication of wait times information and hospital evaluations.

- The OMA recommends that the Ministry of Health and Long-Term Care review hospital funding in Ontario in light of the worldwide trend away from reliance on global budgets. The OMA will be issuing a policy in the coming months that recommends patient-focused funding.

- The OMA encourages the Ministry of Health and Long-Term Care and other health-care stakeholders to continue efforts to integrate the health-care system and to systematically evaluate those efforts to determine which succeed in improving patient care and quality, and to determine their costs.

- Access to experts and increased availability of supportive services in communities is needed to augment medical care and treatment. This is particularly relevant for patients with mental health and substance abuse disorders, and for patients who need community assistance to manage chronic disease. The OMA recommends that the Ministry of Health and Long-Term Care address these unmet needs.

- The OMA recommends that the Ministry of Health and Long-Term Care evaluate the OHIP Schedule of Benefits with regard to providing adequate funding for physicians for electronic and telephone communications between them and their patients.

Transition Planning

In its 2009 report on Ontario’s health system, the Ontario Health Quality Council (OHQC) reports that 1 in 5 (20%) of patients leaving emergency rooms did not know who to contact if they had questions or problems, and 1 in 3 (38%) discharged from hospital did not have that information. These data are based on patient reports. Often, patients are stressed when leaving hospital, so information may have been conveyed, but forgotten if presented verbally, or there may have been language or other communication barriers. Nevertheless, these are indicators that better ways are needed to convey information so that patients are aware of what to do when problems arise.

The Change Foundation, in collaboration with the Ontario Association of Community Care Access Centres, has
Principles of Patient-Centred Care for Physicians

- The OMA believes that optimal patient care is achieved when accountability for health-care outcomes is shared between physicians and their patients. This is most readily accomplished when their relationship is characterized by mutual respect and trust. (from the OMA policy, Accountability in the Health Care Sector)

- Physicians should share decision-making with patients about all aspects of their health care, including treatment options, risks, benefits, and evidence. For patients with mental health or substance abuse illnesses, physicians may need to augment support in the decision-making process. By default, decisions about care reside with patients.

- Physicians should endeavour to communicate information about all relevant aspects of health care to their patients in a manner that is comprehensive and comprehensible.

- To help curtail waste in the system, physicians should endeavour to reduce unnecessary duplication of medical tests and discourage their patients from demanding unnecessary tests.

- Physicians are patient-centred regarding their patients. They should continue to act as advocates for their patients for the resources to meet their health-care needs.

- Physicians may wish to consider ways to organize their practices so that patients have more convenient access to them. This may occur by same-day appointments, e-mail or telephone communications and may require physicians to undertake an organized effort to reduce backlog and improve access. Use of the IHI "plan, do, study, act" cycle may be beneficial. Physicians should read the Canadian Medical Protective Association’s publication, “Using email communication with your patients: legal risks,” available from: www.cmpa-acpm.ca/cmpapd04/docs/resource_files/info_sheets/2005/com_is0586-e.cfm before commencing e-mail communications with patients.

- To facilitate sharing of patient information among physicians and among health sectors, the OMA encourages physicians to avail themselves of opportunities for assistance in obtaining electronic medical records.

- Physicians should take the lead in fostering and promoting compassion and empathy for patients and in promoting behaviours that are patient-centred and positive for patients. This should occur in their own practices including their front office staff, in their health-care teams, and at all stages of the health-care system where they and their patients interact.

- embarked upon a quality improvement project to investigate and make recommendations about care for elderly patients who made the transition from hospital to home or long-term care facility. In one example of hospital to home, they found that there were 247 steps in the hospital to home process, using 9 databases, 35 forms/tracking sheets/brochures, and 11 handoffs/waits for patients. The project was undertaken with the Southeast CCAC and Quinte Health Care’s Trenton Memorial Hospital, and with the Toronto Central CCAC and Toronto Western Hospital. Both systems have undertaken strategies that have succeeded in improving patient transitions. Care co-ordinators work more closely with hospitals to plan discharges, they are in hospitals at certain times each day, allowing families to know when their service is available; they carry smaller caseloads of complex, high-risk patients, providing more intensive support and following the patients through the continuum of care, and they have been added to the emergency department in one hospital. Hospitals are examining the discharge processes, and the CCACs are meeting with hospital partners.

A similar process has been undertaken in New York to reduce the number of steps and the turnaround time for patients in laboratory settings. Laboratories can play a role in promoting patient-centred care by ensuring that the information patients receive about clinical testing and test results is understandable and thus facilitates shared decision-making.

SUMMARY
The Ontario health-care system needs fundamental reform. The OMA definition of patient-centred care is of a system where patients can move freely along a care pathway without regard to which physician, other health-care provider, institution or community resource they need at that moment in time. This system is one that would consider the individual needs of patients and treat them with respect and dignity.
The present system needs fundamental reform to achieve that vision. At the system level, integration, access, funding, and the manner of treating patients needs change. Denmark and the U.S. Veterans Administration present successful models of patient-centred systems.

One of the impediments to a patient-centred system is the manner by which hospitals and other health-care institutions are funded. The present funding models do not encourage co-ordination of care and efficient use of resources. Recent reports have recommended replacing the current systems with modified service-based funding models.

A variety of initiatives have been undertaken in Ontario to improve transition planning, but the problem is multifaceted, expensive, and not amenable to easy solutions. At the institutional level, the demand for beds exceeds the supply, there are inefficiencies in planning, and there is a lack of community resources. The result is that expensive acute care beds are being used for patients who are suitable for alternative levels of care.

Comparatively, Canada rates poorly in access to care. Processes have been developed that are known to help physicians improve access. A variety of capitated primary care models have been implemented in Ontario in the last 10 years to improve access to primary health care. At the system level, other strategies, such as the Wait Times Strategy and the Aging at Home Strategy, have been implemented with mixed results.

Although the medical home concept has been much touted, comprehensive evaluations indicate that the current designs seriously underestimate the time and effort for the changes, overestimate the readiness of information technology, and are undercapitalized. Transformation to a medical home requires a whole practice redesign that cannot be undertaken incrementally. It also requires staffing increases and reductions in patient rosters. Moreover, quality of care differences between the patient-centred medical home and other new models of care are minimal.

At the practitioner level, patient-centred care can improve communication between physician and patient, permit patient participation in decision-making to the extent desired by the patient, and improve access for patients. It may be desirable in and of itself, but its impact on patient outcomes has not been demonstrated. The research relating the effects of patient-centred care to patient outcomes is conflicting and methodologically weak.

Communication of some types of information, such as risk, is particularly difficult and is exacerbated by poor patient health literacy. Patients with mental health or substance abuse illnesses, patients who are very ill, and pediatric patients present particular challenges to the physician.

Patients must be involved in the decision-making process to the extent that they are willing and able to participate. Awareness of biases in decision processes may be useful for physicians in the joint decision-making process. Some types of decisions, such as end-of-life decisions, are particularly difficult for both patients and physicians.

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Ontario Medical Association
150 Bloor St. West, Suite 900
Toronto, Ontario
M5S 3C1

Author
This paper was prepared by Aura Hanna, PhD, a senior policy analyst in the OMA Health Policy Department.

Footnotes
f. The base before increases was: for every 3 physicians, the teams included 4 medical assistants, 1 registered nurse, 0.5 physician assistants or NPs, and 0.3 clinical pharmacists. The clinics have on-site pharmacies, laboratories and radiology suites. The 20 clinics are supported by a system of 4 specialty clinics, 6 urgent care/emergency departments, and 7 hospitals. Each physician had a roster of 2,300 patients.
g. Patients were 1,706 patients who had visited their primary care physician within 2 weeks of the baseline interview. It was a multi-site, nationwide, American clinical trial. Patients rated their involvement in decision-making on a 5-point semantic differential scale 6 months after study entry and the receipt of guideline-concordant depression care at study entry and every 6 months for 2 years. The probabilities of patients receiving guideline-concordant depression care and depression remission were adjusted for overall satisfaction with health care.


l. Conjoint analysis was used to model preferences. This method permits analysis of groups of items that may be preferred, rather than preferences for single items. Preferences can then be ranked. In this analysis, researchers used pairs of attributes related to 3 different hospitals to have subjects indicate their preferences. Attributes related to information transfer, interpersonal collaboration, feedback on progress, opportunity for patients to learn skills to improve health, wait times, care continuity, personal respect for care, patient participation in decision making, hospital accessibility, hospital reception, and opportunity to provide feedback.

m. These researchers constructed experimental situations around both inpatient and outpatient hospital care and asked participants to make multiple choices among hospitals varying in two attributes.

n. Daniel Kahneman won the Nobel Prize in 2002, in large part for his work on understanding how human decisions depart systematically from what would be predicted logically. (Tversky died in 1996, prior to the award, which is not awarded posthumously.)

o. American Heart Association emergency cardiac care guidelines, pediatric advanced life support (PALS) guidelines, and conference on Family Presence during Pediatric Cardiopulmonary Resuscitation and Procedures.


q. Their typical system is to mail surveys to random samples of patients who have received care recently in an NHS trust in England (usually 850 patients per trust) with up to 2 follow-up reminders.

r. Data were obtained from 52 hospital units in Michigan. Measures of patient-centredness were discharge abstracts, insurance claims, and the Picker Inpatient Survey. Outcome measures were unexpected deaths and unexpected complications.


t. The recommendation was that service-based funding be modified for academic centres and rural hospitals and that some areas such as emergency departments may have separate funding arrangements.


References


11. Ontario Ministry of Health and Long-Term Care, Ontario Association of Community Care Access Centres, and Collaborative for Health Sector Strategy, University of Toronto Rotman School of Management;


POLICY PAPER

Patient-Centred Care

Ontario Medical Review

48

June 2010


53. Mead N, Bower P. Patient-centredness: A conceptual framework and review of the empirical literature. Social Science and Medicine, 2000; 51(7): 1087-1110. (purchase only)


Ending the physician-patient relationship

By Stuart Foxman

Disagreements, difficulties, differences, disputes — they can arise between any doctor and patient. Ideally, working together, you can find a way around the stumbling blocks, arrive at common ground, and continue a productive relationship. But what happens when the physician-patient relationship is irretrievably broken?

Doctors have a duty to act in the best interests of their patients, and provide them with quality service. But circumstances can arise that affect a physician’s ability to do just that.

Ending the physician-patient relationship shouldn’t be taken lightly, but is sometimes necessary. The question: When is it appropriate to terminate a patient relationship, and how should you do it?

In its policy on the subject, the College of Physicians and Surgeons of Ontario (CPSO) notes that trust and respect are essential to an effective physician-patient relationship. Several circumstances can erode that foundation to the point that the physician is simply no longer able to effectively care for the patient. The CPSO list isn’t exhaustive, but provides the following examples:

- Patient fraud, such as for the purpose of obtaining narcotics or other drugs.
- Serious threat of harm to the physician, staff and/or other patients.
- Other forms of inappropriate behaviour towards the physician, staff and/or other patients (e.g., foul language, rudeness, argumentativeness, etc.).
- A conflict of interest that compromises the physician’s duty to put the interests of the patient first (e.g., receiving a benefit or a gift, directly or indirectly, from a patient).
- A communication breakdown that makes it impossible to provide quality care.

The decision to discontinue care might have nothing to do with any of the above. For instance, a practice could become too large to manage, meaning the physician needs to decrease the number of patients. In such cases, you must carefully consider the medical needs of patients, as well as factors like their vulnerability and ability to find care in an appropriate timeframe.

In situations involving a breakdown in the relationship, use reasonable efforts to resolve the issues before making any final decision to discontinue care. Ensure that you have a transparent and bona fide rationale for ending the relationship, share it with the patient when appropriate, and document it in the patient’s record.

It may sound harsh, but sometimes termination may be the only choice. The decision to terminate must always be communicated to the patient in writing, and physicians should ideally also communicate the decision in person (except in rare situations where there’s a genuine risk of serious harm).

Help the patient find a new physician or other primary care provider, provide a reasonable amount of time...
for doing so, and ensure the provision of necessary medical services in the interim.

CPSO policy also clearly states situations where it is not appropriate to end the physician-patient relationship. Some examples:

- When patients choose not to follow the physician’s treatment advice (patients are entitled to make decisions about their care, even if the physician doesn’t agree).
- When patients won’t pay a block or annual fee.
- Dismissing a patient based on any prohibited ground in the Ontario Human Rights Code (race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity and expression, age, marital status, family status, disability).
- When care is needed on an urgent or emergency basis, and no other services are available (e.g., a walk-in clinic or local emergency room). Each situation to discontinue care is unique. It’s essential to apply both good clinical judgment and compassion, in a fair and transparent way, to determine the appropriate course of action.

Remember, patients are entitled to be treated with respect during all stages of the physician-patient relationship — even if the relationship faces an end.

Reference

1. For guidance on ending a relationship with a patient, and if it is professionally acceptable to do so, contact the CPSO Physician Advisory Service at 1.800.268.7096, ext. 606, or 416.967.2606. For the CPSO policy on ending a relationship with a patient, visit the CPSO website (www.cpso.on.ca), and look under “Policies” and then “Practice.”

Stuart Foxman (foxmancommunications.com) is a Toronto-based freelance writer who writes frequently about health care.

The Practice Management column is provided by the OMA Member Services Department. Do you have a topic or question you would like to see appear in the Ontario Medical Review? Please let the Practice Advisory Service team know at 416.340.2911, or 1.800.268.7215, ext. 2911, or e-mail: practiceadvisory@oma.org.
For the First Quarter of 2010

During the first quarter of 2010, the Physicians’ Services Incorporated Foundation approved eight health research grants, and one educational fellowship, with a total value of $739,300. Listed below are the recipients, along with project titles and the amount awarded.

**HEALTH RESEARCH GRANTS**

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<tr>
<th>Principal Investigator</th>
<th>Project</th>
<th>Amount</th>
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<tr>
<td>Dr. E. Anagnostou</td>
<td>A pilot, does finding study of pioglitazone in children with ASD.</td>
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<td>Bloorview Kids Rehab</td>
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<td>Dr. C. Birken</td>
<td>PROMOTE: preschoolers at risk-obesity and cardiometabolic risk factors</td>
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<td>Hospital for Sick Children</td>
<td>towards early identification.</td>
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<td>Dr. S. Freedman</td>
<td>Is electrolyte maintenance solution administration required in low-risk</td>
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<td>Hospital for Sick Children</td>
<td>children with gastroenteritis?</td>
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<td>Dr. E. Gandara</td>
<td>GENEVTE: GEne-GeNE interactions and recurrent venous thromboembolism.</td>
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<td>Dr. M. Rodger</td>
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<td>University of Ottawa</td>
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<td>Dr. R. Ilan</td>
<td>Video-based study of communication during handovers:</td>
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<td>Queen’s University</td>
<td>how do intensive care physicians use SBAR?</td>
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<td>Dr. M. Selzner</td>
<td>Ex vivo human liver perfusion: assessment and repair of marginal liver</td>
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<td>University Health Network</td>
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**RESIDENT RESEARCH GRANTS**

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<td>Dr. J. Cook</td>
<td>Differential gene expression in the non-human primate and rat:</td>
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<td>Dr. M. Tymianski</td>
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<td>University Health Network</td>
<td>following stroke.</td>
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<tr>
<td>Dr. M. Lines</td>
<td>Gaining insight into human craniofacial development through the</td>
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<tr>
<td>Dr. K. Boycott</td>
<td>identification of a novel gene for mandibulofacial dysostosis.</td>
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**EDUCATIONAL FELLOWSHIP FOR PRACTICING PHYSICIANS**

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<td>Dr. M.F. Levin</td>
<td>Virtual colonoscopy.</td>
<td>$3,000</td>
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<td>St. Thomas-Elgin Hospital</td>
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**Bill 46 — Excellent Care for All Act**

On May 3, the government introduced the Excellent Care for All Act, which centres on quality and accountability in the health-care system. Foreshadowed in the Throne Speech, this Act affects all hospitals in the province and could also extend to other health-care organizations (HCOs). It is an enabling piece of legislation, and further details will be contained in regulations from the Minister of Health and Long-Term Care and Cabinet, which are expected in coming months.

OMA President Dr. Mark MacLeod was present at the announcement of the legislation and emphasized the OMA’s support for efforts to improve quality in our health-care system. At the same time, he acknowledged that many of the details are yet to be confirmed, and we look forward to further discussion with government as those details are developed over the coming months.

The Act focuses on three main issues: quality, hospital executive compensation, and the role of the Ontario Health Quality Council (OHQC). All three of these themes are related to the government’s renewed effort to improve the quality of our system. Ontario’s definition of a quality health-care system, as provided by the OHQC, is one that is safe, effective, patient-centred, accessible, efficient, appropriately resourced, equitable, integrated, and focused on population health.

This Act would require all hospitals to have a quality committee, tasked with several responsibilities. The membership, composition, and governance of these committees are not detailed, and will be established in coming regulations. Broadly outlined, the membership of these committees will be inter-professional, and they will report directly to hospital boards.

Hospital executives’ compensation will be tied to achieving indicators established in quality plans.

The Ontario Health Quality Council has been given further powers and responsibilities. It still reports on the general quality of our provincial health system annually, but now also makes recommendations on clinical practice guidelines, and funding for specific services and medical devices.

Further information on the Excellent Care for All Act will be provided as the OMA works with government to ensure the highest quality health-care system possible.

**OMA Staff Contact: Andrew MacLean**

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**OMA Staff Contact: Andrew MacLean**

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**CPSO Change in Scope of Practice and Medical Officers of Health**

The College of Physicians and Surgeons of Ontario (CPSO) is developing a new framework to respond to requests from physicians who wish to pursue public health practices as Medical Officers of Health. The CPSO currently addresses the subject of Medical Officers of Health through its Changing Scope of Practice policy. However, the CPSO is focused on a more detailed method to assess prospective Medical Officers of Health who do not have the Royal College designation in community medicine.

The OMA will provide feedback to the CPSO during this consultation process. The OMA will highlight the central role of Medical Officers of Health in public health. In acknowledging the general shortage of Medical Officers of Health, the OMA will emphasize the importance of providing these physicians with appropriate support in order to fulfill their role.

**OMA Staff Contact: Ada Maxwell**

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**Mental Health — Ministry of Health and Long-Term Care Discussion Paper**

In 2009, the Minister of Health and Long-Term Care’s Advisory Group on Mental Health and Addictions was formed to provide advice on the creation of a 10-year mental health strategy. Over the past year, the Advisory Group has conducted consultations across the province with various stakeholders, including the OMA, to examine problems that exist within the current system. Prevalent themes have included a need to strengthen the role of primary care, improved workforce development, better integration of mental health and addiction services, and more efficient emergency department usage.

The Advisory Group is planning to release a final report based on these consultations at the end of June. The OMA will be responding to this report at that time, and will continue to update membershio on further developments.

**OMA Staff Contact: Juhee Makkar**
GARDASIL® is a Registered Trademark of Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc. Used under license.

Prescribing Summary

Therapeutic Classification
Active Immunizing Agent (Suspension for injection)

Indications and Clinical Use
GARDASIL® is a vaccine indicated in girls and women 9 through 26 years of age for the prevention of infection caused by the Human Papillomavirus (HPV) types 6, 11, 16, and 18 and the following diseases associated with these HPV types:
- Cervical cancer
- Vulvar and vaginal cancers
- Genital warts (condyloma acuminata)
- Cervical adenocarcinoma in situ (AIS)
- Cervical intraepithelial neoplasia (CIN) grade 2 and grade 3
- Vaginal intraepithelial neoplasia (VIN) grade 2 and grade 3
- Vaginal all other lesions (VIN grade 2 and grade 3
- Cervical intraepithelial neoplasia (CIN) grade 1

GARDASIL® is indicated in boys and men 9 through 26 years of age for the prevention of infection caused by HPV types 6, 11, 16, and 18 and genital warts caused by HPV types 6 and 11.

Pediatrics (<9 years of age) / Geriatrics (>65 years of age)
The safety and efficacy of GARDASIL® have not been evaluated in children younger than 9 years and in adults above the age of 65.

Contraindications
- Patients who are hypersensitive to the active substances or to any of the excipients of the vaccine. For a complete listing, see the DOSAGE FORMS, COMPOSITION AND PACKAGING in the Supplemental Product Information.
- Individuals who develop symptoms indicative of hypersensitivity after receiving a dose of GARDASIL® should not receive further doses of GARDASIL®.

Special Populations
For use in special populations, see WARNINGS AND PRECAUTIONS, Special Populations.

Safety Information

Warnings and Precautions
General
As for any vaccine, vaccination with GARDASIL® may not result in protection in all vaccine recipients.

This vaccine is not intended to be used for treatment of active external genital lesions; cervical, vulvar, and vaginal cancers; CIN; VIN; or VaIN.

This vaccine will not protect against diseases that are not caused by HPV.

GARDASIL® has not been shown to protect against diseases due to all HPV types.

As with all injectable vaccines, appropriate medical treatment should always be readily available in case of rare anaphylactic reactions following the administration of the vaccine.

Syncope (fainting) may follow any vaccination, especially in adolescents and young adults. Syncope, sometimes associated with falling, has occurred after vaccination with GARDASIL®. Therefore, vaccinees should be carefully observed for approximately 15 minutes after administration of GARDASIL® (See Adverse Reactions, Post-Marketing Adverse Drug Reactions).

Routine monitoring and Pap test should continue to be performed as indicated, regardless of GARDASIL® administration.

Febrile Illness
The decision to administer or delay vaccination because of a current or recent febrile illness depends largely on the severity of the symptoms and their etiology. Low-grade fever itself and mild upper respiratory infection are not generally contraindications to vaccination.

Immunocompromised individuals
Individuals with impaired immune responsiveness, whether due to the use of immunosuppressive therapy, a genetic defect, Human Immunodeficiency Virus (HIV) infection, or other causes, may have reduced antibody response to active immunization. See Drug Interactions in the Supplemental Product Information. No specific data are available from the use of GARDASIL® in these individuals.

Individuals with Bleeding Disorders
This vaccine should be given with caution to individuals with thrombocytopenia or any coagulation disorder only if the benefit clearly outweighs the risk of bleeding following an intramuscular administration in these individuals.

Special Population
The safety, immunogenicity, and efficacy of GARDASIL® have not been evaluated in HIV-infected individuals.

Pregnant Women:
There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, pregnancy should be avoided during the vaccination regimen for GARDASIL®. For more details see WARNINGS AND PRECAUTIONS, Special Populations in the product monograph.

Merck Frosst Canada Ltd. maintains a Pregnancy Registry to monitor fetal outcomes of pregnant women exposed to GARDASIL® vaccine. Pregnant and health-care providers are encouraged to report any exposure to GARDASIL® vaccine during pregnancy by calling 1-800-567-2594.

Nursing Women:
It is not known whether vaccine antigens or antibodies induced by the vaccine are excreted in human milk. Women may breastfeed without being contraindicated to lactating women. For more details see WARNINGS AND PRECAUTIONS, Special Populations in the product monograph.

Adverse Reactions
In clinical trials, GARDASIL® was generally well tolerated when compared to placebo (Amorphous Aluminum Hydroxypatite Sulfate (AAHS) Adjuvant or saline).

Clinical trial adverse drug reactions
The most commonly reported vaccine-related injection-site adverse experiences (reported at a greater frequency than that observed among placebo recipients) 1 to 5 days postvaccination, in females 9 through 26 years of age in clinical trials with GARDASIL® (n = 5,088), AAHS Adjuvant-containing placebo (n = 3,470) and saline placebo (n = 320), respectively, were pain (83.9%, 75.4%, 48.6%), swelling (25.4%, 15.8%, 7.3%), erythema (24.7%, 18.4%, 12.1%), pruritus (3.2%, 2.6%, 0.6%) and bruising (2.8%, 3.2%, 1.6%). The most commonly reported vaccine-related systemic adverse experiences (reported at a greater frequency than that observed among placebo recipients) 1 to 5 days postvaccination, in males 9 through 26 years of age in clinical trials with GARDASIL® (n = 3,092), AAHS adjuvant-containing placebo (n = 2,029) and saline placebo (n = 274), respectively, were pain (61.5%, 50.8%, 41.6%), erythema (16.7%, 14.1%, 14.5%) and swelling (13.9%, 9.6%, 8.2%). The most commonly reported vaccine-related systemic adverse experiences (reported at a greater frequency than that observed among placebo recipients) 1 to 15 days postvaccination, in males in clinical trials with GARDASIL® (n = 3,092) and for AAHS adjuvant- and non-AAHS adjuvant-containing placebo (n = 2,303), respectively, were headache (7.5%, 6.7%) and fever (6.2%, 5.1%). For more details on adverse events reported during clinical trials, see Adverse Reactions in the Supplemental Product Information.

To report a suspected adverse reaction, please contact Merck Frosst Canada Ltd. by toll-free telephone: 1-800-567-2594 Toll-free fax: 1-877-428-8675

To regular mail: Merck Frosst Canada Ltd., P.O. Box 1005, Pointe-Claire – Dorval, QC H9R 4P8

Administration

Dose and Dose Adjustment
GARDASIL® should be administered intramuscularly as 3 separate 0.5 mL-doses according to the following schedule:

- First dose: at elected date
- Second dose: 2 months after the first dose
- Third dose: 6 months after the first dose

Individuals are encouraged to adhere to the 0, 2, and 6 months vaccination schedule. However, in clinical studies, efficacy has been demonstrated in individuals who received all 3 doses within a 1-year period. If an alternate vaccination schedule is necessary, the second dose should be administered at least 1 month after the first dose, and the third dose should be administered at least 3 months after the second dose (see Clinical Trials, Schedule flexibility in the product monograph).

Patients who are hypersensitive to the active substances or to any of the excipients of the vaccine. For a complete listing, see Supplemental Product Information for full listing)

Adverse Drug Reaction Overview

GARDASIL® must not be injected intravascularly. Neither subcutaneous nor intradermal administration has been studied. These methods of administration are not recommended.

The prefilled syringe is for single use only and should not be used for more than one individual. For single-use vials, a separate sterile syringe and needle must be used for each individual.

The vaccine should be used as supplied; no dilution or reconstitution is necessary. The full recommended dose of the vaccine should be used.

Shake well before use. Thorough agitation immediately before administration is necessary to maintain suspension of the vaccine. After thorough agitation, GARDASIL® is a white, cloudy liquid. Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration. Discard the product if particulates are present or if it appears discolored.

Instructions for Use

Single-dose Vial Use: Withdraw the 0.5 mL dose of vaccine from the single-dose vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents. Once the single-dose vial has been penetrated, the withdrawn vaccine should be used promptly, and the vial must be discarded.

Prefilled Syringe Use: Inject the entire contents of the syringe.

For instructions for using the prefilled single-dose syringes preassembled with needle guard (safety device, see DOSAGE AND ADMINISTRATION, Instructions for Use in the product monograph).

Storage and Stability
Store refrigerated at 2°C to 8°C. Do not freeze. Protect from light. GARDASIL® should be administered as soon as possible after being removed from refrigeration.

GARDASIL® can be administered provided total time out of refrigeration (at temperatures at or below 25°C) does not exceed 72 hours.
The most frequently reported serious systemic adverse experiences in the entire study population (25,513 individuals), only 0.04% of the reported serious systemic adverse experiences (1 individual who received placebo). In addition, there were 2 cases of sepsis, 1% where the incidence in the vaccine group was greater than or equal to 0.1% and at least 0.03% where the incidence in the placebo group is shown in ADVERSE REACTIONS, Tables 3-4 of the product monograph.

Serious Adverse Experiences in the Entire Study Population
A total of 0.2% (53) boys and 0.2% (51) girls ages 9 through 26-year-old boys and men who received both doses of GARDASIL® (1% of the total study population) had a serious systemic adverse experience following any vaccination visit during the clinical trials for GARDASIL®. Out of the entire study population (25,513 individuals), only 0.04% of the reported serious systemic adverse experiences were judged to be vaccine related by the study investigators. The most frequently reported serious systemic adverse experiences for GARDASIL® compared to placebo and regardless of causality were:

- Headache (0.02% GARDASIL® [3 cases] vs. 0.02% placebo [2 cases]).
- Gastroenteritis (0.01% GARDASIL® [2 cases] vs. 0.01% placebo [1 case]).
- Appendicitis (0.04% GARDASIL® [5 cases] vs. 0.01% placebo [1 case]).
- Pelvic inflammatory disease (0.01% GARDASIL® [2 cases] vs. 0.02% placebo [2 cases]).
- Urinary tract infection (0.01% GARDASIL® [4 cases] vs. 0.02% placebo [3 cases]).
- One case (0.01% GARDASIL®: 0.0% placebo) of thrombocytopenia and 2 cases (0.03% GARDASIL® vs. 0.01% placebo) of fever, were reported as serious systemic adverse experiences that occurred following any vaccination visit.

In addition, 1 individual in the clinical trial in the group that received GARDASIL® reported two injection site serious adverse experiences (injection site pain and injection-site joint movement impairment).

Deaths
Across the clinical studies, 31 deaths were reported in 25,513 (0.1%) individuals. One death was judged to be possibly vaccine-related. This death occurred following any vaccination visit during the clinical trials for GARDASIL®. There were no deaths in the clinical studies.

Use with Other Vaccines:
Use with Steroids:
Use with Hormonal Contraceptives:
Use with Systemic Immunosuppressive Medications:
Use with Anti-Inflammatory Drugs, Antidepressants, Antidiabetics, Antihypertensives, Anticonvulsants, and Antimetabolites:
Use with Antiplatelet Agents:
Use with Anticoagulants:
Use with Common Medications:
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Adverse Drug Reactions
Clinical Trial Adverse Drug Reactions
In clinical trials (5 placebo-controlled), individuals were administered GARDASIL® (p = 13.99%) at a frequency at least 1.5% higher than the placebo group (n = 3.72%) for the study population, and approximately 2 to 6 months thereafter. GARDASIL® demonstrated a favorable safety profile when compared with placebo (ARASL adjuvant or saline). Few individuals (0.2%) discontinued due to adverse experiences. In all except one of the clinical trials, safety was evaluated using vaccination report card (ARASL) aimed at identifying all 14 days after each injection of GARDASIL® or placebo.

The vaccine-related adverse experiences that were observed among recipients of GARDASIL® were at a frequency of at least 1.0% and at least 0.03% where the incidence in the placebo group is shown in ADVERSE REACTIONS, Tables 3-4 of the product monograph.

Of those girls and women who reported an injection site reaction, 94.3% judged their injection site adverse reaction to be mild or moderate in intensity.

In addition, bronchospasm was reported very rarely as a serious adverse experience.

All-cause Systemic Adverse Experiences
All-cause systemic adverse experiences for 9 through 26-year-old recipients of GARDASIL®, that were observed at a frequency of greater than or equal to 1% where the incidence in the vaccine group was greater than or equal to the incidence in the placebo group are shown in ADVERSE REACTIONS, Tables 3-4 of the product monograph.

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Deaths
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A lower dose of sulfonylurea may be required to reduce the risk of hypoglycemia when used in combination with metformin or a sulfonylurea, when metformin or the sulfonylurea used alone, with diet and exercise, does not provide adequate glycemic control. Geriatrics (≥65 years of age): No dosage adjustment is required based on age, however greater sensitivity of some older individuals cannot be ruled out (see WARNINGS AND PRECAUTIONS and DOSAGE AND ADMINISTRATION). Pediatrics (<18 years of age): Safety and effectiveness of ONGLYZA in pediatric patients have not been established. Therefore, ONGLYZA should not be used in this patient population.

CONTRAINDICATIONS

Patients who have had a history of any serious hypersensitivity to this drug or to any ingredient in the formulation or to another DPP-4 inhibitor.

Safety Information

WARNINGS AND PRECAUTIONS

For complete information on warnings and precautions, please also consult the supplemental product information section.

General

ONGLYZA (saxagliptin) should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis.

Endocrine and Metabolism

A lower dose of sulfonylurea may be required to reduce the risk of hypoglycemia when used in combination with ONGLYZA (see SUPPLEMENTAL PRODUCT INFORMATION — ADVERSE REACTIONS and DOSAGE AND ADMINISTRATION).

Special Populations

Pregnant Women: There are no adequate and well-controlled studies in pregnant women. As animal reproduction studies are not always predictive of human response, ONGLYZA is not recommended for use in pregnancy.

Nursing Women: Saxagliptin is secreted in the milk of lactating rats. It is not known whether saxagliptin is excreted in human milk. Therefore, ONGLYZA should not be used by a woman who is nursing.

Pediatrics (<18 years of age): Safety and effectiveness of ONGLYZA in pediatric patients have not been established. Therefore, ONGLYZA should not be used in this patient population.

Geriatrics (≥65 years of age): Of the total number of subjects (N=4148) studied in controlled clinical safety and efficacy studies of ONGLYZA, 634 (15.3%) patients were 65 years and over, of which 59 (1.4%) patients were 75 years and over. No overall differences in safety or effectiveness were observed between subjects 65 years and over and younger subjects. While this clinical experience has not identified differences in responses between the elderly and younger patients, greater sensitivity of some older individuals cannot be ruled out.

Saxagliptin and its major metabolite are known to be eliminated in part by the kidney. Renal function should be assessed prior to initiating ONGLYZA and periodically thereafter in geriatric patients because they are more likely to have decreased renal function. Care should be taken in prescribing ONGLYZA in this population based on renal function (see WARNINGS AND PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Cardiovascular — Patients with Congestive Heart Failure: A limited number of patients with history of congestive heart failure participated in clinical studies with ONGLYZA. In clinical trials, ONGLYZA patients with NYHA Class III or IV congestive heart failure were excluded. Patients with history of congestive heart failure were included in small number (in total: 2% of patients exposed to ONGLYZA in clinical trials). Use in this population is not recommended.

Hepatic Insufficiency: There are limited clinical data in patients with hepatic impairment taking multiple doses of ONGLYZA. The use of ONGLYZA in patients with moderate to severe hepatic impairment is not recommended.

Renal Impairment: No dosage adjustment is recommended for patients with mild renal impairment. Clinical experience with ONGLYZA in patients with moderate or severe renal insufficiency including those with end-stage renal disease (ESRD) requiring hemodialysis is limited. Use in these patients is not recommended. Assessment of renal function is recommended prior to initiation of ONGLYZA, and periodically thereafter (see DOSAGE AND ADMINISTRATION).

Monitoring and Laboratory Tests

Response should be monitored by periodic measurements of blood glucose and HbA1c levels. Assessment of renal function is recommended prior to initiation of ONGLYZA and periodically thereafter.

ADVERSE REACTIONS

For complete information on adverse reactions, please also consult the supplemental product information section.

Adverse Drug Reaction Overview

ONGLYZA (saxagliptin) was generally well tolerated in controlled clinical studies as an add-on to metformin and as an add-on to sulfonylurea with the overall incidence of adverse events similar to that reported with placebo.

In a placebo-controlled clinical study of patients receiving ONGLYZA 5 mg or placebo as an add-on to metformin, the incidence of serious adverse events was 9.9% and 5.6% respectively. The most commonly reported adverse events, reported regardless of causality and more common with ONGLYZA than placebo, were nasopharyngitis and bronchitis. Discontinuation of therapy due to adverse events occurred in 7.3% of 4.5% of patients, respectively.

In a placebo-controlled clinical study of patients receiving ONGLYZA 5 mg or placebo as an add-on to sulfonylurea (glyburide), the incidence of serious adverse events was 3.6% and 5.6% respectively. The most commonly reported adverse events, reported regardless of causality and more common with ONGLYZA than placebo, were hypoglycemia and urinary tract infection. Discontinuation of therapy due to adverse events occurred in 4.7% and 3.4% of patients, respectively.

DRUG INTERACTIONS

For complete information on drug interactions, please also consult the supplemental product information section.

The metabolism of saxagliptin is primarily mediated by CYP3A4/5. In vitro studies, saxagliptin and its major pharmacologically active metabolite neither inhibited nor induced CYP3A4. In addition, in vitro studies, saxagliptin and its major pharmacologically active metabolite neither inhibited CYP1A2, 2A6, 2C8, 2C9, 2C19, 2D6, 2E1, nor induced CYP1A2, 2B6, 2C9. Therefore, saxagliptin is unlikely to alter the metabolic clearance of coadministered drugs that are metabolized by these enzymes. Saxagliptin is neither a significant inhibitor of P-glycoprotein (P-gp) nor an inducer of P-gp, and is unlikely to cause interactions with drugs that utilize these pathways.

The in vitro protein binding of saxagliptin and its major metabolite in human serum is below measurable levels. Thus, protein binding would not have a meaningful influence on the pharmacokinetics of saxagliptin or other drugs.

Drug-Drug Interactions

Effect of other drugs on saxagliptin

In studies conducted in healthy subjects, the pharmacokinetics of saxagliptin and its major metabolite were not meaningfully altered by metformin, glyburide, pioglitazone, digoxin, simvastatin, diltiazem, ketoconazole, esomeprazole, aluminum hydroxide + magnesium hydroxide + simethicone combination, or furosemide. These drugs are considered unlikely to cause a clinically meaningful interaction with ONGLYZA.

Effect of saxagliptin on other drugs

In studies conducted in healthy subjects, saxagliptin did not meaningfully alter the pharmacokinetics of metformin, glyburide, pioglitazone, digoxin, simvastatin, diltiazem, or ketoconazole. ONGLYZA is considered unlikely to cause a clinically meaningful interaction with these drugs.

To report suspected side effects:

By toll-free telephone: 866-234-2345
By toll-free fax: 866-678-6789
Online: www.healthcanada.gc.ca/saefc
By email: Canada.Vigilance@hc-sc.gc.ca

Administration

DOSAGE AND ADMINISTRATION

Dosing Considerations

ONGLYZA (saxagliptin) may be taken with or without food.

Recommended Dose and Dosage Adjustment

The recommended dose of ONGLYZA is 5 mg once daily.

Renal Impairment: Use of ONGLYZA in patients with moderate to severe renal impairment, including patients with end stage renal disease requiring hemodialysis is not recommended.

Hepatic Impairment: Use of ONGLYZA in patients with moderate to severe hepatic impairment is not recommended due to lack of clinical experience with this patient population.

Pediatrics (<18 years of age): Safety and effectiveness of ONGLYZA in pediatric patients have not been established. Therefore, ONGLYZA should not be used in this patient population.

Geriatrics (≥65 years of age): No dosage adjustment for ONGLYZA is required based solely on age (see WARNINGS AND PRECAUTIONS).

Missed Dose

If a dose of ONGLYZA is missed, it should be taken as soon as the patient remembers. A double dose of ONGLYZA should not be taken on the same day.
### Supplemental Product Information

**ADVERSE REACTIONS**

Clinical Trial Adverse Drug Reactions

Because clinical trials are conducted under very specific conditions, adverse reactions observed in the clinical trials may not reflect the reactions observed in practice and should not be compared to the results of clinical trials involving other drugs. Adverse reactions observed in clinical trials are useful for identifying adverse reactions and for approximating frequencies.

The incidence of adverse reactions, reported regardless of causality assessment, in a 2% of patients treated with either ONGLYZA 5 mg or placebo as an add-on to metformin or add-on to sulfonylurea (glyburide) are shown in Table 1.

Table 1: Adverse Reactions (Regardless of Investigator Assessment of Causality) in the Add-on to Metformin Study and in Add-on to Sulfonylurea* Study (24-week Short-term Studies and Long-term Extension) Reported in ≥ 2% of Patients Treated with Either ONGLYZA 5 mg or Placebo in at Least One Study

<table>
<thead>
<tr>
<th>Body system/organ class</th>
<th>ADR event</th>
<th>Number of Patients (%)</th>
<th>Number of Patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>Anemia</td>
<td>11 (6)</td>
<td>3 (1.7)</td>
</tr>
<tr>
<td></td>
<td>Hypotension</td>
<td>4 (2.3)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Endocrine and metabolic disorders</strong></td>
<td>Abnormal glucose tolerance</td>
<td>14 (7.5)</td>
<td>23 (12.6)</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td>11 (6)</td>
<td>8 (4.5)</td>
</tr>
<tr>
<td></td>
<td>Glyburide</td>
<td>8 (4.5)</td>
<td>16 (9.2)</td>
</tr>
<tr>
<td></td>
<td>Hyperlipidemia</td>
<td>17 (9.4)</td>
<td>21 (11.7)</td>
</tr>
<tr>
<td><strong>Kidney and urinary system disorders</strong></td>
<td>Cystitis</td>
<td>7 (3.7)</td>
<td>2 (1.1)</td>
</tr>
<tr>
<td></td>
<td>Cystitis</td>
<td>7 (3.7)</td>
<td>2 (1.1)</td>
</tr>
<tr>
<td></td>
<td>Dysuria</td>
<td>0</td>
<td>4 (2.2)</td>
</tr>
</tbody>
</table>

**Reproductive, thoracic, and abdominal disorders**

<table>
<thead>
<tr>
<th>ADR event</th>
<th>Number of Patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body system/organ class</td>
<td>Add-on to Metformin</td>
</tr>
<tr>
<td><strong>Musculoskeletal system disorders</strong></td>
<td>Anorexia</td>
</tr>
<tr>
<td></td>
<td>Pruritus</td>
</tr>
</tbody>
</table>

A meta-analysis of duration of exposure to double-blind study trials, including exposure to the cimetidine or placebo of 2 weeks (Standard Deviation (SD) of 2 weeks), showed the number of patients with adverse reactions was not significantly different between the two groups. The mean duration of exposure to double-blind study trials, including exposure to the cimetidine or placebo of 2 weeks (SD of 2 weeks), showed the number of patients with adverse reactions was not significantly different between the two groups.

Simvastatin: On the basis of animal data, the effects of ONGLYZA on lymphocyte counts in patients with lymphocyte abnormalities (e.g. human immunodeficiency virus) is unknown.

### Effect of other drugs on saxagliptin

- **Saxagliptin and other CYP2C9 substrates**
  - Simvastatin: Coadministration of multiple once-daily doses of saxagliptin (10 mg) and simvastatin (40 mg), a CYP3A4/5 substrate, increased the Cmax of saxagliptin by 21%; however, the AUC of saxagliptin was unchanged. Therefore, simvastatin is considered unlikely to cause a clinically meaningful interaction with ONGLYZA. Meaningful interactions of ONGLYZA with other OCT-1 and OCT-2 substrates would not be expected.
- **Saxagliptin and other CYP2C8 substrates**
  - Digoxin: Coadministration of multiple once-daily doses of saxagliptin (10 mg) and digoxin (0.25 mg), a P-gp substrate, did not alter the pharmacokinetics of saxagliptin. Therefore, digoxin is considered unlikely to cause a clinically meaningful interaction with ONGLYZA. Meaningful interactions of ONGLYZA with other CYP2C8 substrates would not be expected.

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**Mechanism of Action**

Saxagliptin is a patient, selective, noncompetitive, DPP-4 inhibitor. Saxagliptin demonstrates selectivity for DPP-4 versus other DPP enzymes, including DPP-8 and DPP-9. Saxagliptin has extended half-life in the DPP-4 active site, prolonging its inhibition of DPP-4. Saxagliptin exerts its actions in patients with type 2 diabetes by slowing the inactivation of incretin hormones, including glucagon-like peptide-1 (GLP-1). The concentration of active (intact) GLP-1 incretin hormone is increased.

Incretin hormones are released by the intestine throughout the day and concentrations are increased in response to a meal. These hormones are rapidly inactivated by the enzyme DPP-4. The incretins are part of an endogenous system involved in the physiologic regulation of glucose homeostasis. When blood glucose concentrations are elevated, GLP-1 and GIP increase insulin synthesis and release from pancreatic beta cells. GLP-1 also lowers glucagon secretion from pancreatic alpha cells, leading to reduced hepatic glucose production. The concentration of GIP is reduced in patients with type 2 diabetes but saxagliptin increases active GIP concentration. By increasing active GIP concentrations, saxagliptin increases postprandial insulin release and decreases postprandial glucose concentrations in the circulation in a glucose-dependent manner.

In the event of an overdose, appropriate supportive treatment should be initiated as dictated by the patient’s clinical status. Saxagliptin and its active metabolite are eliminated primarily via the urine. For management of a suspected drug overdose, contact your regional Poison Control Centre.

**Interactions with Laboratory Tests**

No studies of the effects of ONGLYZA on the ability to drive and use machines have been performed. However, ONGLYZA is not expected to affect the ability to drive and use machines.

**OVERDOSE**

In the event of an overdose, appropriate supportive treatment should be initiated as dictated by the patient’s clinical status. Saxagliptin and its active metabolite are eliminated primarily via the urine. For management of a suspected drug overdose, contact your regional Poison Control Centre.

**ACTION AND CLINICAL PHARMACOLOGY**

**Mechanism of Action**

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In patients with type 2 diabetes and hyperglycemia, these changes in insulin and glucagon levels may lead to lower hemoglobin A1c (HbA1c) and lower fasting and postprandial glucose concentrations.
Classifieds

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Fax: 416.340.2232
E-mail: margaret.lam@oma.org

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OFFICE SPACE AVAILABLE

Bloor & Bay Street: 582 sq. ft. office available in a prestigious and meticulously managed professional building. Ideal for a medical doctor, psychiatrist or psychologist. Access to excellent retail amenities and TTC. Close to U of T. Favourable terms and rates.

Contact: Andrew Gallifent, Sales Representative, Lennard Commercial Realty, Brokerage
Tel. 416.366.3183, ext. 232
E-mail: agallifent@lennard.com

Boxgrove Medical Centre — now open: Four-storey, 60,000 sq. ft. medical building located at the 9th Line and Highway 407. Prime medical space available for lease. X-ray, lab, rehab and urgent care on-site.

Contact: Howard
Tel. 416.357.7509

Central Toronto, Forest Hill: 970 sq. ft. medical or dental office. Waiting room and four examining rooms. Prestige location, available immediately. Free parking, TTC directly out front. Comfortable ambiance, “just like home.”
E-mail: officemedical@rogers.com

Dufferin/Clark: A turnkey medical office up to 2,500 sq. ft. Great location, four exam rooms and a reception, free parking. Beside dentist, physiotherapist, dietician, and a pharmacy. Dense residential and commercial area.
Contact: Hany
Tel. 647.501.4269

Existing medical office for part-time use: Available Tuesday, Thursday, Friday and Saturday. Downtown, on subway. Tel. 416.573.3990

Fully furnished medical clinic available: Newly renovated clinic in busy plaza. EMR available, run the clinic the way you want and save major overhead. Pay a split 85:15 (negotiable) or just pay minimal rent. Keep all your billings for three months! Relocation expenses paid. Signing bonus. Near Dufferin and Steeles. Other sites in Brampton and Aurora also available.
Tel. 416.839.2767
E-mail: uniqueclinic@hppinc.ca

Islington Professional Centre — medical space available now: Be a part of a 12-storey medical centre one block north of Islington Ave. and Bloor. On-site: pharmacy, diagnostic imaging, audiology, radiology, laboratory, physiotherapy. Custom-designed suites from 750 sq. ft. Across from Islington subway station, surface and underground parking available. Competitive rental rates, nightly suite cleaning, card access security system as well as scheduled site guard. Entirely smoke-free property.
Tel. 905.273.7411

Mississauga — excellent medical office for family physician: Fully furnished, recently renovated suites with private underground free parking. Great location in a medical centre, close to Credit Valley and Trillium Hospital in a dense residential and commercial area. Physiotherapist and pharmacy on-site. Low rent and relocation incentives.
Tel. 416.587.9430

Office space in North York: Part-time family doctor looking for another part-time family doctor or specialist to cost-share office space. Located in modern medical building with free parking and easy subway access at Yonge/Finch.
Contact: Dr. Todd Levy
Tel. 416.573.8339
E-mail: tlevymd@rogers.com

Following are the classified advertising deadline dates for the next six issues.

<table>
<thead>
<tr>
<th>ISSUE</th>
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</tr>
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<td>January 10</td>
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Ontario Medical Review

June 2010
Classifieds

PAR-Med Realty Ltd.: Specializing in medical office building leasing, property management, and building sales. We have over 70 medical office buildings in our portfolio throughout Ontario. For leasing inquiries:
Contact: Brad Stoneburgh
Tel. 416.364.5959, ext. 403
E-mail: bstoneburgh@par-med.com
Website: www.par-med.com

REAL ESTATE

Disney/Orlando real estate: Unbelievable buying opportunities, former Ontario resident.
Contact: Kathy Jaworski
Cozy Homes Real Estate, Inc.
Tel. 352.223.3389
E-mail: kat-florida@live.com

Medical unit for sale in a very busy building located at Kennedy/Finch with a densely populated South Asian community. Well upgraded, with five patient observation rooms. Prime location in an excellent professional building.
Tel. 416.891.8291 or 416.880.9613

Toronto — Chaplin Estates: 3,500 sq. ft. executive home with main floor self-contained attached medical office. Two separate driveways. Steps to subway. Five plus one bdrms. Four baths, two-car garage. $1,399,000. Many tax advantages.
Tel. 416.400.9805

Toronto east/practice and building! Exceptional opportunity to own both a vibrant practice, plus the building it’s in! Doctor retiring after 50 years! Situated in a residential setting adjacent to transportation. Hwy. 401/Warden area. Turnkey situation! Transition support as well.
Contact: Bob Edwards, Royal LePage
E-mail: bobedwards@trebnet.com

Toronto — medical clinic on Danforth Ave.: 2,500 sq. ft. renovated space. Parking x6, 10% ROI or for own use, $525K.
Tel. 416.485.9882

LOCUM TENENS

Mississauga — busy GP clinic seeking summer locum. Possible long-term association. Flexible scheduling.
E-mail: kingsbridgemc@yahoo.ca

POSITIONS VACANT

90:10 split or flat rent: Brampton, Markham, Etobicoke. Brand new, bright, clean medical centres seeking GPs for walk-in and family practice. F/T or P/T. Relocate or start a new practice. New grads and specialists welcome. EMR or paper. Turnkey. Call in strictest confidence.
Tel. 647.403.1810

$200/hour — GP required immediately at Mississauga outpatient clinic. Hours: 8 a.m. to 11 p.m. seven days a week.
Contact: Angela
Tel. 905.897.8928

$250 per hour — pediatrician, internist, surgeon, subspecialist in busy outpatient clinic in Mississauga.
Contact: Dr. Stein
Tel. 416.464.0238

Attractive split: Very busy, established professionally run clinics in north Etobicoke seeking MDs to join existing group of seven MDs. Flexible hours and shifts. Very pleasant staff and patient profile.
Contact: Dr. Damji
Tel. 416.834.2807
E-mail: alkarim@damji.ca

Tel. 416.839.2767
E-mail: uniqueclinic@hppinc.ca

Tel. 416.839.2767
E-mail: uniqueclinic@hppinc.ca

Beautiful Ottawa — fluently bilingual FT or PT family physician/general practitioner to join East Ottawa FHT; take over 1,000+ established patient base; work within an interdisciplinary team to provide comprehensive primary health care and health promotion; salary, premiums and benefits package. EMR-integrated and training. Free parking. For November 1, 2010.
Contact: EOCFHT
c/o Physician Recruitment
3095, St-Joseph Blvd., Suite 202
Orléans, ON K1E 3W6
E-mail: d_jeroux@esfestottawa.ca
Website: www.esfestottawa.ca

Brampton, Ontario: Full-time/part-time family physicians and GP psychotherapist required for busy family practice/walk-in clinic. Attractive modern office. Option to join FHG. High fee-for-service split or flat monthly rate.
Tel. 416.949.3830
Fax: 647.340.2586
E-mail: bramptonfamilyhealth@gmail.com

Downtown Toronto — family physicians/general practitioners: F/T, P/T, or partner to join an established practice with large existing patient base. Professionally managed and efficiently run. Located at the University/Dundas intersection. Flexible working hours and opportunity for joining a FHG.
Contact: Dominic
Tel. 416.271.8585
Fax: 416.551.5611
E-mail: mdll@mac.com

Etobicoke — dynamic physician needed for a busy, beautifully renovated EMR practice in medical building. Build your practice from huge wait list. Start working at no cost, then 80:20 split or fixed fee.
Contact: Joe
Tel. 416.564.7585
E-mail: youannas@rogers.com

Excellent practice opportunity: Looking for two GPs for brand new medical space located in the town of Sutton on the beautiful shores of Lake Simcoe, only 45 min. from the GTA. Considered “underserviced,” so signing bonus offered and have a full practice in no time. Attractive overhead costs. Ownership opportunities available. Inquire for details. 647.827.7800

Ontario Medical Review

June 2010
Classifieds

Family and walk-in doctor: Locum/part-time/full time. Instant full practice. Extremely busy! Congenial colleagues and low overhead (20%). EMR, FHG, partnership option, >700K billing for a five-day work week.
Contact: Thomas Van
Tel. 647.227.5088
E-mail: thomvan@rogers.com

Family physician needed, F/T, P/T for a busy clinic in Markham established for 20 years with large patient base, pharmacy, lab on-site to join other family physician (FHG). Modern clinic, EMR systems, great split (90:10), ideal for new graduates. Also looking for locums and retired physicians. No contract required and full administrative support.
Contact: Neelam 647.409.3535,
Ashok 416.578.4141
E-mail: bharga@rogers.com

Family physicians required F/T or P/T for North York high-volume walk-in or family practice. Ideal for new grads or retired MDs. No contract required. Flexible shifts, FHG bonuses, EMR, great split, helpful staff.
E-mail: dswbas@gmail.com

Family physician wanted to take over a retired physician’s practice and share space with experienced MD. Flexible hours, turnkey office, labs and pharmacy on-site, 726 Bloor St. West (at Christie St.), 80:20 split.
Tel. 416.516.5244
E-mail: bloorwestclinic@yahoo.ca

Full-time or part-time medical doctors required for a busy walk-in located in downtown Mississauga.
Contact: Adel
Tel. 416.904.2929
905.897.6160 (office)

General surgeon — Brockville General Hospital is seeking a general surgeon to fill a full-time vacancy. You will be one of four general surgeons. Preferred skills include laparoscopy, endoscopy, and ERCP. The Brockville General is a two-site hospital with a combined total of 141 beds, serving a catchment area of 96,000. A recent $32 million dollar expansion (2003) saw the addition of four new OR suites, digital imaging and CT. Tertiary care/academic centres in Ottawa and Kingston are just one hour away. Brockville, Ont. (population 22,000), is conveniently located along Hwy. 401 in the beautiful Thousand Islands region; two hours west of Montreal and three hours east of Toronto. UAP eligible.
Contact: Carlene MacDonald
Physician Recruiter
Tel. 613.345.5645, ext. 1154
E-mail: macca@bggh-on.ca
Website: www.bggh-on.ca,
www.brockville.com

GP needed for Spanish and Portuguese speaking patients in two locations in the GTA. Terms negotiable.
Tel. 416.749.2084 or 905.270.2713
Fax: 905.270.3626

Hiring medical/family doctors for family practice/walk-in, in busy Richmond Hill medical centre.
Tel. 647.280.0648
Fax: 905.737.3906
E-mail: hedy@towerhillhealth.com

Loblaws Superstore: North York walk-in clinic/family practice located inside Loblaws requires family physician/pediatrician. Flexible hours and very attractive split.
Tel. 416.519.3937

Looking for physicians: Brand new 9,000 sq. ft. medical office in Mississauga. Walk-in clinic/metabolic centre, 4,000 sq. ft. We are committing to 25 patients a day. The centre is opening in three to four months.
Contact: Mohamed Razakazi
Tel. 416.568.4737
E-mail: mrazakazi@gmail.com
Contact: Amit Puri
Tel. 416.230.4499
E-mail: amit.puri@gmail.com

Looking immediately for general practitioners (F/T, P/T) for very busy family practice/walk-in medical centres in Toronto. Retiring physicians and IMGs welcome. Supervision available. Excellent split offered.
Contact: Bindu
Tel. 416.876.7166
E-mail: bjiangmian@hotmail.com

MD associates needed for busy walk-in/family practice clinics in Brampton and Mississauga. Flexible hours and attractive split. Work at your own pace. New grads and retiring MDs welcome.
Contact: Mona
Tel. 416.624.0657
E-mail: mlubana1@gmail.com

MedSleep’s network of clinics are committed to providing the highest quality sleep services across Canada. We strive to be pioneers in sleep medicine utilizing the latest in technology, promoting education, and participating in clinical research and the advancement of new treatments. MedSleep is seeking full-time or part-time experienced sleep medicine physicians, with any co-specialty, to join our growing medical team as we expand our services in Ontario. Our clinics provide clinical assessment and diagnostic sleep studies (portable and in-house polysomnography) for the full spectrum of sleep disorders. We offer low overhead with opportunity for both fee-for-service and additional third-party income. To submit your CV, ask questions, or to learn more about MedSleep:
Contact: Sue Wiercinski
E-mail: jobs@medsleep.com
Website: www.medsleep.com

MedVisit Doctors Housecall Service:
Greater Toronto or Ottawa. PT or FT. New higher OHIP fees and housecall bonuses now in effect. Flexible shifts. Drivers available.
Contact: Dr. Burko
Tel. 416.631.0298
E-mail: drburko@medvisit.ca
Website: www.medsvisit.ca/doctors

Methadone doctor required to work part time in a busy clinic in Toronto. Please reply via e-mail.
E-mail: methadonedr@gmail.com

Mississauga — gynecology, other specialties, and part-time walk-in. Gynecologist to assume established practice one to two days per month. Also seeking internal medicine, GP psychotherapist one to two days/month. Walk-in shifts also available on a part-time basis.
Tel. 416.844.8340
E-mail: doctorsearch@hotmail.com

Mississauga west — physician needed full time or part time in a busy medical building. Free parking, on-site lab and X-ray. Brand new office with support staff and full computerization, pharmacy next door. Split or monthly rate; you decide what works for you. Accepting family physicians willing to relocate.
Contact: Mr. Karia
Tel. 416.616.3014
E-mail: tec1@rogers.com

Ontario Medical Review

June 2010
Niagara — busiest clinic in region:
Urgent Care Niagara – established clinic with proven volume and 25-year track record. Opening for full-time or part-time experienced MDs to join core group of physicians servicing busiest urgent care/walk-in centres in the region. Better financial remuneration possible than FHG/FHN. Competitive split. State-of-the-art Internet patient registration, facilities and systems with electronic medical records, great staff and fun place to work in the heart of Niagara. Possibility of extended time off on rotating basis with other physicians.
Contact: Medical Director
Tel. 905.464.7820
Website: www.urgentcareniagara.com/doctors.htm

North York, Ontario: Paperless computerized new clinic in a medical building with pharmacy, lab and X-ray. No set-up cost. Part time or full time. Move existing practice or build up from walk-in clinic. Support staff for EKGs, PFTs, venipuncture for income supplement.
Contact: Mr. Samuel
Tel. 647.400.0401

Opportunity for a family physician to join a family medicine clinic in downtown Toronto for walk-in shifts, with possibility to build own practice. Interested candidates should send their résumé.
Fax: 416.901.8870
E-mail: md@facymedicine.com

Opportunity in Richmond Hill & midtown Toronto, Ontario: Well-established family practice of family physicians seeking physician full time or part time. Walk-in shifts also available. No financial commitments, clinics are fully EMR integrated (EMR training included), On-site lab. Above-average compensation package.
Tel. 905.884.1017 (direct office line)
E-mail: mjiwan@uptownhealthcentre.com

Ottawa — family medicine full-time or part-time positions available in an attractive building in a beautiful new community. Free parking and on-site lab.
Contact: Dr. Ashkian
Tel. 613.822.0171 (9 a.m. to noon, or 1 p.m. to 3 p.m., Monday to Friday)
Fax: 613.822.1838
E-mail: drhaigashikian@gmail.com

Physician needed: Enjoy medicine more! Enjoy medicine again! If you have an interest in this important clinical area, we would like you to join our busy clinic. We need family doctors, GPs, GP psychotherapists, psychiatrists, semi-retired, part time or full time. We are open weekends and weeknights. We provide comfortable offices, professional staff, excellent financial arrangements, professional supervision, and CME programs are available. Check out our website.
Contact: Anna
Tel. 416.229.2399 or 1.888.229.8088
Website: www.medicalpsychclinic.org

Physicians — Kelowna, BC: Medikel Clinics Ltd. seeks physicians from across Canada for well-established family practice. IMGs also welcome. Kelowna is located in the heart of the Okanagan in south-central BC. Kelowna has excellent schools, recreational facilities, restaurants, and wineries. Truly a great place to live and work.
Contact: Maria Varga
E-mail: officemanager@medi-kel.net

Physicians opportunity: Join a leading medical practice group that is exclusively focused on one of the fastest growing and most rewarding fields in medicine today: anti-aging, wellness and rejuvenation medicine. Attractive compensation package, located in midtown Toronto, treating a highly motivated patient base. Improve your life as well as that of your patients.
Contact: Dr. Sven Grail
Tel. 416.785.1828, ext. 206

Psychiatrists, medical psychotherapists are needed at a busy private mental health clinic.
Contact: Sue
Tel. 416.778.1496

Richmond Hill, Ontario: Richmond Hill After-Hours Clinic requires physicians for daytime shifts 9 a.m. to 5 p.m., as well as evenings and weekends. Guaranteed minimum 70:30 split.
Contact: Dr. Ian Zatzman
Tel. 905.884.7711
Fax: 905.553.5360
E-mail: medz@rogers.com

Specialists — Brampton, Ontario: Dermatologist, pediatrician, internist, and psychiatrist required for medical centre with several GPs and large patient base. Attractive modern office with seven days/week reception service. Fee-for-service split or low flat monthly rate.
Tel. 416.949.3830
Fax: 647.340.2586
E-mail: bramptonfamilyhealth@gmail.com

Contact: Dr. Connie D’Astolfo
Tel. 905.553.7746
E-mail: info@spinegroup.ca
Website: http://spinegroup.ca/blog/

Tel. 416.839.2767
E-mail: uniqueclinic@hppinc.ca

PRACTICES

Busy, established pediatric practice for sale in Thornhill area. Easy access in growing pediatric area. Interested, please inquire.
E-mail: practise4sale@hotmail.com

E-mail: abrahamse@trytel.net

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Reach 29,000+ physicians, residents and medical students every issue.
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Advertisers’ Index

A&L Computers........................................... 13
AstraZeneca........................................... 32-33
Elecompack Systems Inc .................... 29
Klinix Software ........................................ IFC
Merck Frosst Canada ......................... OBC
OMA Corporate Hotel Directory .......... 24
OMA Insurance Services ...................... 4
OMA Legal Services ............................ 30
OMA Physician Health Services ...... 14
OMA Practice Management and Advisory Services Seminars 24, 51
OMR Classifieds ....................................... 28
Record Storage & Retrieval Services ...... 30
Record Storage & Retrieval Services ...... 30
TD Bank Financial ................................... 2
Worldwide Quest International .......... 9
XWave ................................................ IBC

Prescribing Information:
Gardasil ........................................... 54-55
Onglyza .............................................. 56-58
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- GENITAL WARTS
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in boys and men 9-26 years of age

The QUADRIVALENT HPV vaccine

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SELECTED IMPORTANT SAFETY INFORMATION
The most commonly reported vaccine-related injection-site adverse experiences in clinical trials with GARDASIL® in females (n = 5,088), amorphous aluminum hydroxyphosphate sulfate (AAHS) adjuvant-containing placebo (n = 3,470) and saline placebo (n = 320), respectively, were pain (83.9%, 75.4%, 48.6%), swelling (25.4%, 15.8%, 7.3%), erythema (24.7%, 18.4%, 12.1%), and pruritus (3.2%, 2.8%, 0.6%). The most commonly reported vaccine-related systemic adverse experience in females was fever: 10.3% for GARDASIL® (n = 5,088) vs 8.6% for AAHS adjuvant- and non-AAHS adjuvant-containing placebo (n = 3,790). The most commonly reported vaccine-related injection-site adverse experiences in clinical trials with GARDASIL® in males (n = 3,092), AAHS adjuvant-containing placebo (n = 2,029) and saline placebo (n = 274), respectively, were pain (61.5%, 50.8%, 41.6%), erythema (16.7%, 14.1%, 14.5%) and swelling (13.9%, 9.6%, 8.2%). The most commonly reported vaccine-related systemic adverse experience in males was headache: 7.5% for GARDASIL® (n = 3,092) vs 6.7% for AAHS adjuvant- and non-AAHS adjuvant-containing placebo (n = 2,303).

This vaccine is not intended to be used for treatment of active external genital lesions; cervical, vulvar or vaginal cancers; CIN, VIN, or VaIN. This vaccine will not protect against diseases that are not caused by HPV. Routine monitoring and Pap test should continue to be performed as indicated, regardless of GARDASIL® administration. Pregnancy should be avoided during the vaccination regimen for GARDASIL®. As for any vaccine, vaccination with GARDASIL® may not result in protection in all vaccine recipients. Syncope (fainting) may follow any vaccination, especially in adolescents and young adults. Syncope, sometimes associated with falling, has occurred after vaccination with GARDASIL®. Therefore, vaccinees should be carefully observed for approximately 15 minutes after administration of GARDASIL®.

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