Committed and on course

Physicians take lead to improve health-care system for all

16 Compensation Panel priorities move ahead with board approval
18 Doctors share their experiences treating the uninsured in Ontario
27 Examining the reasons behind the primary care crisis
30 Three former leaders take us inside the role of OMA president
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OMA MISSION
Advocate for and support doctors. Strengthen the leadership role of doctors in caring for patients.

OMA VISION
To be the trusted voice in transforming Ontario’s health-care system.

OMA CORE VALUES

Respectful: We treat everyone with dignity, and value diverse experiences and perspectives.

Innovative: We seek opportunities to be creative and explore future possibilities.

Bold: We courageously pursue best practices, new ideas, solutions and opportunities to improve.

Responsive: We listen and connect to understand.

Transparent: We are genuine and candid in our interactions, and we hold ourselves accountable.
Ontario doctors urge government to create permanent program for uninsured patients (p.18)
Temporary COVID-era initiative improved health-care access, ensured physicians were paid for their services.

OMA prioritizing solutions to Ontario's primary care crisis (p.27)
Chair of SGFP says key is getting doctors to work in their scope and removing administrative burden.

OMA 143rd Annual General Meeting highlights (p.33)
Discussions and solutions on improving health care in Ontario take centre stage in Windsor.

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It is truly an honour to be the 142nd OMA president. I am excited to be on this journey with you, my physician colleagues across the province.

I may be a new face to you as I’ve never held a formal leadership position in the OMA. But new faces bring fresh perspectives, and we should be willing and encouraged to hear diverse ideas and consider different viewpoints on the issues that bind us.

Furthermore, I take great pride in being the first East Asian president in our organization’s history, marking a significant step toward promoting diversity, representation and inclusivity in health-care leadership.

As your president, I will build on the advocacy of my predecessors and stand up for our profession and colleagues, ensuring that the government and public are hearing our collective voices. I am committed to working with you respectfully and collaboratively. I am here to listen and be your ally as we continue leading the changes our system needs. We must build on our recent accomplishments and strengthen our system to work better for patients and physicians.

The OMA recently released Prescription Progress Report 2023, the first of our planned annual progress reports, reflecting on the successes and path forward for health-care transformation. This report identifies the actions taken by the provincial government over the past 18 months on the 87 recommendations in Prescription for Ontario: Doctors’ 5-Point Plan for Better Health Care. Our report shows that it has taken action on 51 of the 87 recommendations, demonstrating our positive, solutions-focused relationship. The government is listening to us, and we are encouraged by its response to some of the foundational changes we called for, including the creation of community diagnostic and surgical centres, more investment in primary care and steps to license more foreign-trained physicians.

Despite these successes, we still have a long way to go. Our Progress Report identifies three urgent priority areas that need immediate attention:

- Ensuring access to team-based primary care led by a family doctor
- Reducing physician burnout
- Addressing the lack of access to co-ordinated community-based care

I am optimistic about the productive discussions I’ve had to date with key government officials. Each official is committed to working with the the OMA to ensure that every Ontarian has access to the health care that is their fundamental right. I will continue to nurture these relationships as we work together to fix the gaps in our health-care system. I would love to hear from you and look forward to learning, growing and celebrating alongside you.

Dr. Andrew Park
OMA President
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Moving forward with urgent priorities
Advocacy efforts continue to strengthen health-care system

Health-system solutions, driven by the experience and expertise of physicians, are the hallmark of the OMA’s Prescription for Ontario: Doctors’ 5-Point Plan for Better Health Care — our plan to fix Ontario’s health-care system.

Since its release in October 2021, progress has been made. Our Prescription Progress Report 2023, released in May, highlights steps taken by government to address Ontario’s health-care issues and the gaps that need to be filled. It also identifies urgent priorities for 2023 that will guide our advocacy over this year.

Progress Report priorities
Our 2023 urgent priorities were identified through consultations and surveys with members, stakeholders, the business community and the public:

- Fixing the crisis in primary care
- Addressing physician burnout
- Expanding and integrating home and community-based care
  These fall within the Prescription’s five pillars:
  - Reducing wait times and the backlog of services
  - Expanding mental health and addiction services in the community
  - Improving and expanding home care and other community care
  - Strengthening public health and pandemic preparedness
  - Giving every patient a team of health-care providers and linking them digitally

Advocating for better health care
Prescription for Ontario is our key advocacy document, setting out priorities and pathways to address health-care challenges all across Ontario.

Collaboration is key to improving Ontario’s health-care system. We have had success working with MPPs and the government to advance OMA solutions. We are encouraged by action taken by the provincial government – from committing funds to expanding programs to introducing legislation – related to 51 of the OMA’s 87 recommendations.

The government responded to some of the foundational changes we called for including the creation of community diagnostic and surgical centres and more investment in primary care.

We will continue to consult members, stakeholders and the public about our most urgent priorities. In the meantime, we continue to work collaboratively with the government and health-care providers to ensure the vision for co-ordinated care becomes reality.

OneOMA – uniting members with their association
Recently introduced, the purpose of OneOMA is to provide a seamless experience when you interact with your association.

We need to do a better job connecting you with all the benefits the OMA has to offer. OneOMA will raise awareness of what the OMA can do for Ontario’s doctors, helping them take advantage of the supports we offer for personal and professional needs.

Whether you’re seeking information on discounts, legal advice, billing education, or wish to become a leader or advocate to advance our larger mandate, OneOMA’s goal is to support Ontario’s doctors in delivering better health care. Read more about OneOMA on page 25.

Transforming health care
Your association is in a good position to build on our work as a trusted voice in transforming Ontario’s health-care system.

The OMA will continue to build on this momentum to advocate on the critical issues that matter most to doctors and the health of all Ontarians.

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OMA Chief Executive Officer
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My journey with the OMA
Reflecting on lessons learned and path forward

What was it like to be president of the OMA? That is a question many people have asked me since I completed my one-year term as OMA president. Whether I am speaking to a politician, a journalist or a colleague, I answer that question the same way: “Incredible.”

Being OMA president was an enormous privilege and a challenging responsibility. I am proud of my year and the relationships I built with the OMA staff who support us, the media who are eager to hear from us and the government that is listening. I also came to understand how critical it is to work alongside other health-care-system stakeholders to advance our health-system solutions.

I learned a lot about myself this past year. In particular, I learned that imposter syndrome is a myth. Showing up in a leadership space you have never occupied can bring anxiety and self-doubt. That doesn’t mean you don’t belong there – it means you are a human being. In fact, that leadership space needs you. Especially you. How liberating to bring your authentic self forward and have a positive impact.

My goal as immediate past president will be to exercise this belief in myself and those around me. Physicians are regarded highly as leaders. Let’s leverage that for the good that needs to be done inside the health-care system.

My work focused on advocating for three immediate, priority solutions developed by the OMA to ease the strain on the health-care system – licensing more foreign-trained doctors, creating integrated ambulatory centres and increasing access to palliative care.

We have seen progress in these areas, which strengthens my resolve to have physicians at the decision-making table. The new publicly funded community surgical and diagnostic centres will help reduce wait times and create more capacity. We will continue to insist that these centres be integrated with hospitals and incorporate a human health resource strategy, and that no Ontarian will ever pay out of pocket for a medically necessary service.

Another achievement was locking in patient-centred virtual care in the new Physician Services Agreement, creating access to health services from the comfort of a patient’s home. This helps reduce barriers to care.

I know these solutions do not eliminate physician burnout or solve everything we are struggling with as a profession. We need to keep respectfully communicating with the change-makers. We want to be on the forefront of positive change, and we have been. Thank you for working so incredibly hard to make this happen.

Thank you for your support this year. Meeting many of you was an incredible highlight and to those I haven’t met yet, know that I will stay engaged in the conversations that matter. I will be guided by a deep moral conviction to care, for you as my peers, always for our patients and for a health-care system that needs us all.

Dr. Rose Zacharias
OMA Immediate Past President
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The OMA General Assembly has added three new priorities to its working agenda as progress continues on the association’s governance transformation.

OMA members submitted 60 ideas to the Priority and Leadership Group this year, Dr. Veronica Legnini, General Assembly Steering Committee chair, told delegates to the group’s annual meeting in Windsor this past May. Delegates narrowed down the ideas to three priorities for assembly panels to tackle in 2023.

The Advocacy Panel will explore enhanced access to physician-led multi-disciplinary care. The Issues and Policy Panel will prioritize initiatives to motivate the recruitment of family physicians. And the Compensation Panel will look into allowing physicians the option to bill by time instead of fee code.

“The mandate of the Priority and Leadership Group is to set member-driven priorities for the organization that are achievable and aligned with the strategic plan, helping to modernize the organization and health care in Ontario,” said Dr. Legnini, a family doctor in Kingston.

The new slate of priorities landed just as the OMA board approved for implementation the first recommendations to come out of the governance transformation process, launched two years ago.

The first approved recommendations, presented by the Compensation Panel, are designed to optimize the engagement of OMA members in the negotiations process.

New organization structures intended to increase the OMA’s relevance with members has had a positive impact, Dr. Legnini said.

For example, panel chairs at the Windsor meeting reported large numbers of applicants coming forward to be part of the working groups.

“It’s exciting to see how many members are willing to put their hands up to work in a new way with the OMA on behalf of members. We have been intentional in fostering this interest in the hopes of seeing just this outcome,” she said.

“I have seen this renewed interest in members from diverse backgrounds and who have never worked within the OMA before. New blood and fresh perspective, balanced with experience, is critical to keeping the work moving forward.”

Engagement is also reflected in the record number of ideas members submitted for the group’s consideration. The 60 ideas were reduced to six top topics for each panel. PLG delegates then spent much of their two-day meeting reviewing, discussing and sometimes refining the ideas, followed by a final vote to choose the three top 2023 priorities.

“
It’s exciting to see how many members are willing to put their hands up to work in a new way with the OMA on behalf of members."

Dr. Veronica Legnini
The Advocacy Panel’s 2023 priority to enhance access to physician-led multi-disciplinary care aims to ensure patients obtain the right care at the right time in the right place (by the best-suited and more affordable health-care provider), reducing wait times and improving MD wellbeing.

The Issues and Policy Panel’s task is to prioritize initiatives that motivate the recruitment of family physicians. Suggestions included needing better remuneration for family physicians, a reduction in the burden of administrative forms and the promotion of family practice as a career among learners.

The top new priority for the Compensation Panel would allow physicians the option to bill by time instead of fee code, giving family doctors and consulting specialists the flexibility to deal with multiple needs in one visit (for instance, for patients with complex problems) and still be paid fairly for their work.

The meeting’s delegates also heard some of the lessons learned over the first two years of the renewed General Assembly’s process.

Panels realized, for instance, that there must be realistic expectations around timelines. Member-driven processes are limited by members’ schedules. And the OMA can influence, but not force, external stakeholders to implement recommendations.

Moreover, the panel and PLG process isn’t designed to deliver quick fixes but works better at creating mid- to long-term solutions.

Dr. Legnini said that once PLG delegates have a firm understanding of the types of ideas and timeline the structure can deal with, it should become clearer to the membership at large.

“I certainly hope that the recently approved recommendations will have a tangible effect for members (during) the upcoming negotiations cycle.”

She told the PLG meeting that the next big project for the General Assembly Steering Committee will be providing better support to the networks — the groups associated with areas of practice such as academic, diagnostic, medical, primary care, regional and surgical.

With panels and working groups dealing with eight priorities, the steering committee also wants to take a look at the general assembly’s capacity to take on additional priorities, she said.

Panel chairs reported to the Windsor meeting on the progress of their work so far. Each year, starting in 2021, the PLG has set new priorities. The panels do initial research and investigation on the topics chosen, including holding meetings with subject matter experts and representatives from other jurisdictions.

Then the panel chooses a working group from OMA member applicants and turns the more focused priority over to that group to develop recommendations.

**Progress from the Issues and Policy Panel**

The Issues and Policy Panel has completed scoping, the focusing and refining stage of panel work, on its 2021 priority — data support for work and health human resources. It has also created a working group to generate recommendations.

Panel chair Dr. Michael Finkelstein, deputy medical officer of health for Toronto Public Health, said there were 28 applicants for the seven-member working group, which has held its first meeting. “We trust this group is well on its way to developing recommendations.”

The panel is seeking applicants for a working group for its 2022 priority — centralized lab requisitions for imaging and lab testing.

When scoping the priority, the panel met with representatives from OceanMD, Ontario Health, the Ministry of Health and the eHealth Centre of Excellence to learn about virtual e-referrals, how imaging providers interface with electronic medical records, and a government-led plan for a central portal to order laboratory tests.

Efforts taken to determine the scope of the task paid off, Dr. Finkelstein told the Windsor meeting.

“The panel has learned that there is a tremendous amount of work going on in this area that I think will influence the working group to come up with great recommendations,” he said.

While the government and some stakeholders are well ahead on identifying technology solutions to improve ordering bloodwork, the imaging side has not been addressed in the same way.
“We’re giving direction to the working group, which is just about to be appointed, to focus on the imaging side,” he added.

Progress from the Compensation Panel
Due to the constraints of negotiation timetables, the Compensation Panel was quick off the mark in addressing its first priority — restructuring negotiations to optimize constituency group engagement.

Acting as a working group, the panel embarked on its own detailed work on the priority, producing the first set of recommendations to be approved by the OMA Board of Directors for implementation under the new governance model.

Panel chair Dr. Robert Dinniwell, a radiation oncologist in Niagara, said the panel incorporated findings from the negotiations process and a review conducted by the consulting firm SuccessMap in its final recommendations. The panel also looked at how other medical associations across Canada engage with constituency groups during the negotiation process.

The panel’s second priority was to revamp the OHIP-eligible rejected claims process to compensate physicians who provide services for uninsured patients. During the scoping process, the panel met with Alberta and Saskatchewan medical association representatives to find out how uninsured claims are dealt with in those provinces.

The panel received 37 applicants from which it created a seven-member working group. That group will look at common rejected claim issues, including facilitating payment for patients who should be insured but face some type of barriers, and payment for patients who are not eligible for OHIP but received urgent, non-deferrable care.

Progress from the Advocacy Panel
The Advocacy Panel’s 2021 priority — reducing delays in patient flow — struck a particular chord with members, judging from the number of physicians who offered to sit on the working group. The panel narrowed the field down from 55 highly qualified applicants, said Advocacy Panel Chair Dr. Lisa Salamon.

“It was really inspiring to read through their applications and see how passionate they are about this topic,” said Dr. Salamon, an emergency physician at Scarborough Health Network and Sinai Health.

The panel used a diversity lens to choose the final seven-member working group, considering characteristics including years of practice, location, specialty, gender and lived experience, she said.

The panel’s 2022 priority was to develop a comprehensive health human resources strategy, including a portable licence that is time-restricted to underserved areas.

As it refined the scope of the 2022 priority, the panel met with University of Ottawa professor Dr. Ivy Bourgeault, who has a PhD in community health and is an expert in health human resources.

Dr. Salamon said the panel will soon be recruiting a working group for the 2022 priority.

Katherine Kerr in an Edmonton, Alta.-based writer.

“The panel incorporated findings from the negotiations process and a review conducted by the consulting firm SuccessMap in its final recommendations.”

Dr. Robert Dinniwell
The OMA Board of Directors has approved a sweeping set of recommendations to improve member engagement in the negotiation process.

The Compensation Panel’s plan to make negotiations more transparent and responsive to members is the first to make its way through the panel process under the association’s governance transformation. The final proposal includes a suite of actions to improve engagement under four buckets: preparation, education, communication and structure. Some recommendations – such as informing members how to relay concerns through appropriate channels and providing opportunity for two-way communication – can be implemented in the short term. Others, such as the creation of a more formal education program on negotiation for physician leaders, are medium- to long-term goals.

Once fully implemented, physician leaders in constituency groups will have a more uniform understanding of the negotiations process, said Dr. Veronica Legnini, chair of the General Assembly’s Steering Committee, in a recent interview.

“We will also ensure clear delineation of the roles and responsibilities of each participant in the negotiations process, from the board, OMA staff, physician leaders and the membership.

“Finally, the recommendation on ensuring true two-way communication between physician leaders and the Negotiation Task Force will allow us to bring the membership along the process as it unfolds,” the Kingston family physician added.

The Priority and Leadership Group identified two compensation priorities in 2022: improving negotiation engagement and dealing with compensation for uninsured patients. The Compensation Panel then received the priorities for oversight of the recommendations developed. In this case the panel’s work on the negotiations priority was compressed due to negotiations between the OMA and the province. Work began last August.

Since the next round of negotiations will begin in October, the panel decided to forgo appointing a separate working group for the negotiations engagement priority and took on the detailed tasks itself.

Dr. Goldszmidt said being part of a working group is where one can influence change and recommends colleagues get involved if they can.
“We incorporated findings from the negotiations process and the review conducted by SuccessMap consultants into our process. We looked at other medical associations across the country and how they manage engagement of their constituency groups,” Dr. Robert Dinniwell told the PLG meeting in Windsor on May 6.

Panel members come with varied experience, some having previously provided input on negotiations, offering specific tariff expertise. “The panel itself is extremely highly functional. There’s a huge variety of skill sets, and we have broad representation both on an individual specialty level, ranging from the specialty of primary care through to surgery, anesthesia, diagnostic medical and psychiatry,” Dr. Dinniwell said in a recent interview. “And then there are members, like (vice-chair) Eric Goldszmidt, who have vast experience in terms of the tariff piece, or physician compensation.”

Dr. Goldszmidt said OMA staff from various groups across the organization provided valuable feedback to the panel and were informed on its direction moving forward. “On their end, they could already start to try and position themselves to implement some of the themes and some of the ideas.”

Dr. Dinniwell added that OMA members are already seeing results with access to more educational materials, which they offered input into, and information on the negotiations process.

“If you look at the negotiations web page, it’s brand new. And some of its content is already influenced by us.”

The ultimate goal, said Dr. Goldszmidt, is to provide more transparency on a process that is somewhat mysterious to the average member. “They are at least going to understand much better how the process works, why it works. Their leaders will be better engaged on their behalf, and whatever they can be told, they will be told at appropriate times.”

Dr. Nikolina Mizdrak, chair of the NTF and a family physician at Toronto Western Hospital, said the NTF’s work and goals align with that of the Compensation Panel and they share a commitment to transparency to the extent possible.

“It’s about education, education, education. And the NTF, Compensation Panel and many people that we’ve spoken to from the districts and the sections would all agree that transparency is very important in terms of the negotiating process,” she said.

For transparency’s sake, the Compensation Panel recommends increasing the number of physician leaders involved in ‘Sunday night’ calls during which the NTF provides updates about ongoing negotiations. Non-disclosure agreements are used to protect sensitive information and mitigate risks during talks with the ministry.

“We’re going to really try to take what the Compensation Panel said about the Sunday night calls and work that in with our plan to try to be as transparent as we possibly can within the scope of the NDAs,” Dr. Mizdrak said. Adding more section executives to the calls, however, shouldn’t impact dialogue between the NTF and section executives attending the updates, she added.

Drs. Goldszmidt and Dinniwell said working on the Compensation Panel has been rewarding and urged more OMA members to participate on either panels or working groups.

“If you actually want to get your hands dirty, you want to be on the working group,” said Dr. Goldszmidt, adding that the Compensation Panel had a tough time choosing the working group for its second priority on compensation for non-insured patients because there were so many strong candidates.

The overall governance restructuring, Dr. Dinniwell said, has introduced initiatives that position Ontario’s doctors as thought leaders. “This fits into that strategic initiative to build out in a way that the OMA seems to recently have done extraordinarily well. The OMA has brought forward some phenomenal work of a very high value that should affect meaningful change in our system.”

Katherine Kerr in an Edmonton, Alta.-based writer.
Ontario doctors urge government to create permanent program for uninsured patients

Temporary COVID-era initiative improved health-care access, ensured physicians were paid for their services

By Abigail Cukier

Pediatrician Dr. Shazeen Suleman was visiting a Toronto refugee shelter in the summer of 2022 when she met a child who had arrived in Canada as an asylum seeker and had never seen a doctor.

Dr. Suleman knew immediately that the child had a serious genetic condition that can cause heart and blood issues. She quickly arranged urgent bloodwork and appointments with multiple specialists so the child could get the care they needed.

She was able to treat them and others in the refugee shelter, and be paid for her work, through an initiative called the Physician and Hospital Services for Uninsured Persons Program. The Ontario government established the program in March 2020 as a temporary measure to reduce the spread of COVID-19 by ensuring that any uninsured person in Ontario had access to medically necessary services performed in hospital. It also covered limited physician services performed in the community.

If the program had not existed, “there’s a very real possibility that the first time I would have seen that child would have been in the ICU or in the emergency room or worse, not at all,” said Dr. Suleman, who is part of St. Michael’s Hospital, Unity Health Toronto.

But the government ended the program on March 31 of this year, resulting in barriers to care for patients without health insurance and meaning doctors will once again not be paid for treating them. This is why the Ontario Medical Association and physicians like Dr. Suleman are working to convince the government to reinstate the program or replace it with a similar, long-term initiative.

“The day it was announced the program would end, I felt physically sick thinking of the children who don’t have insurance,” Dr. Suleman said. “They’re not just numbers. I see their faces in my mind and my heart is breaking.”

An Ontario Medical Association analysis found that 7,000 Ontario physicians provided 400,000 care epi-
sodes to patients without insurance during the program.
“The abrupt discontinuation (of this program) could be
detrimental to the lives of some of our patients,” Dr. Cathy
Faulds, chair of the OMA Board of Directors, said in an
email. “During the pandemic, the ability to treat and man-
age patients, regardless of their ability to pay, expedited
access to care for many marginalized and vulnerable pop-
ulations.”

Uninsured patients a top priority
The issue of compensation for treating uninsured patients, identified as one
of its top two priorities by the OMA’s Compensation Panel, was approved by
the board of directors in June. The OMA is also working with the Ontario Hospital
Association and other stakeholders to produce solutions to present to the pro-
vincial government.

The challenge of treating uninsured patients began long before the pan-
demic. According to a 2016 Wellesley Institute report, Health Care Access for
the Uninsured in Ontario, there could be as many as 500,000 uninsured people
in the country, many of them in Canada’s largest province.

Patients without OHIP coverage include
newcomers waiting for permanent residency status, some
temporary foreign workers, international students with
limited health-care coverage and undocumented people
with no official immigration status.

It also includes marginalized Ontarians who may be
unable to obtain or renew their health card due to situ-
ations that make it difficult to go through the application
process, such as homelessness, mental illness, language
barriers or lack of transportation to a Service Ontario cen-
tre. OHIP cards must be renewed every five years.

Studies have shown that these patients often expe-
rience poorer health outcomes. While this may partly
be due to precarious living conditions, it can also be
attributed to limited access to health care. A study in
Refuge: Canada’s Journal on Refugees, describes how
those without insurance delay seeking care out of fear of
the cost or deportation, and they report barriers to access-
ing care when they do seek it.

A 2016 study called Emergency Room Visits by
Uninsured Child and Adult Residents in Ontario, Canada
analyzed emergency department visits by insured and
uninsured patients over a nine-year span. It found that unin-
sured patients were 43 per cent more likely than insured
patients to be triaged as severe. They were also more likely
to leave the emergency department without treatment or

“The day it was announced
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Dr. Shazeen Suleman
COVID-19 gave us this unplanned natural experiment where we were able to do the right thing and provide people the care that they needed, when they needed it.

Dr. Ritika Goel

Program offered fair remuneration for physicians

Dr. Faulds points to the 7,000 physicians who were paid for services under the Physician and Hospital Services for Uninsured Persons Program. Now that it has ended, “they would not be paid for their work going forward. This is not equitable nor fair remuneration for health-care providers.”

Under the program, physicians in the community could bill OHIP using temporary k-codes, while care provided in a hospital was reimbursed by the hospital at the same rates as OHIP. Hospitals were reimbursed by Ontario Health for both operational and physician costs.

Dr. David Esser, a physician surgical assistant at the Scarborough Health Network, said it is especially frustrating to treat an Ontario patient who has been unable to renew his or her health card. “Some patients just don’t have the resources or ability to go and do the work that is required to get the card, even though it’s documented that they’ve had a card,” he said.

“You feel you’ve been taken advantage of, when you are expected to step up and do this for free. Then the flip side is, if you want to pursue payment, how do you speak to somebody about this who is having hardships?

“It is frustrating to have the program end, because it allowed us to freely provide services patients required and not have to worry about chasing after them or all the paperwork involved.”

Dr. Ritika Goel, a family physician in Toronto who has worked extensively with uninsured people, said the program helped patients who were afraid of seeking care finally feel like they belonged. “COVID-19 gave us this unplanned natural experiment where we were able to do the right thing and provide people the care that they needed, when they needed it.”

Dr. Goel said prior to the program, patients without health insurance who went to a hospital were asked for money up front or received care and then were sent a bill for thousands of dollars.

“Those scenarios unfortunately happened quite regularly before this program. And we’re starting to hear of similar stories again,” she said. “I am thinking of an elderly man who had quite a serious infection who left the emergency room because he was asked for $500. There was a middle-aged man who mentioned that his family had gone into debt back home so that he could access a surgery for a tumour. I’ve heard cases of pregnant women asked for cash while they were in labour.”

The elderly man with the infection instead went to Dr. Goel’s office and through her decade-long advocacy...
efforts, she ensured he received the complex care he needed through a specialist and the residents at their clinic, even though he couldn’t pay. “Providers often have to do a ton of advocacy. And that is when the patient is working with a clinic that understands the system. Many in the health-care system don’t know what to do when someone shows up without a health card.”

Other programs offer limited help
While other programs exist for patients without insurance, they have limitations. The Interim Federal Health Program covers health care for groups such as refugee claimants, victims of human trafficking or resettled refugees. The type and length of coverage depends on an individual’s immigration status and health-care providers must sign up to provide care through the program.

Ontario has a network of about 100 Community Health Centres, not-for-profit organizations that provide primary care and health promotion programs. Their mandate is to provide health care to those who otherwise have barriers to accessing services.

Some CHCs have determined that uninsured residents are a priority population and receive funds from the Ministry of Health to cover non-CHC services for these clients (for example, lab tests and specialist visits). But not every CHC receives funding to provide this comprehensive care.

“Community Health Centres are limited because there are not enough of them, so there are long wait lists,” Dr. Suleman said. “There is also limited access to specialists. If a patient needs to see a specialist, that can be very difficult. If they need to get blood testing or other investigations done, that can be very difficult.

“There are some incredible and generous people who donate their time to see children without insurance in their offices. There are community groups that band together to provide pop-up clinics and support. But these are all small attempts to patch this hole that was filled during this program.”

Dr. Suleman said providing timely care to more people also benefits the health-care system. “Preventive medicine and primary care are more effective in the long run, being able to provide care when it is needed, at the time it is needed, in the place that it is needed in the community, rather than in the acute-care setting,” she explained.

Uninsured Persons Program found that it was highly cost-effective, given the significant costs of hospitalization that result from delaying care. The analysis found that physician fees in the community were about $15 million from the program’s inception to March 2023. The hospitals’ costs to cover physician fees and operations for the program have not been made publicly available.

Dr. Esser believes the program proved that health-system access needs a rethink. He said people in marginalized groups are disproportionately affected by lack of access to health care. “These populations need an extra touch that we’re not quite delivering on. But we have the capacity as a society to really look after these people and it will benefit us all.”

Dr. Faulds said the OMA is committed to working with the Ontario government to fill this gap in equitable access to care. “Developing a system to facilitate OHIP cards for the marginalized and vulnerable is the path forward,” she said. “The barriers for citizens who are not housed or have disabilities impairing them from completing the current processes need to be removed.”

Dr. Suleman said she is grateful for the OMA’s support on this cause. “I think it’s important for the public and policy-makers to hear from our association. We are the ones who see families and see the consequences.”

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Abigail Cukier is a Hamilton, Ont.-based writer.
CIBINQO is indicated for the treatment of patients 12 years and older with refractory moderate-to-severe atopic dermatitis, including the relief of pruritus, who have had an inadequate response to other systemic drugs (e.g., steroid or biologic), or for whom these treatments are not advisable.

**A new, highly selective oral JAK1 inhibitor for moderate-to-severe AD***

**Once-daily dosing**

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Refer to the page in the bottom-right for additional safety information and for a web link to the Product Monograph discussing:

- The most serious warnings and precautions regarding: serious infections; malignancies; thrombosis; major adverse cardiovascular events
- Other relevant warnings and precautions regarding: driving and operating machinery; dose-dependent increase in blood lipid parameters, lipid monitoring and management; hematological abnormalities; use with other potent immunosuppressants; vaccination; monitoring and laboratory tests; fertility; special populations, including women of childbearing potential, pregnancy, breastfeeding, and geriatrics
- Conditions of clinical use, adverse reactions, drug interactions and dosing instructions

In addition, the page contains the reference list relating to this advertisement.

AD=atopic dermatitis; JAK1=Janus kinase 1.

* Clinical significance unknown.
CIBINQO is indicated for the treatment of patients 12 years and older with refractory moderate-to-severe atopic dermatitis, including the relief of pruritus, who have had an inadequate response to other systemic drugs (e.g., steroid or biologic), or for whom these treatments are not advisable.

Contact your Pfizer representative to learn more about CIBINQO

Significantly more CIBINQO patients achieved ≥75% improvement in the EASI score from baseline (defined as EASI-75) at Week 12 vs. placebo²

<table>
<thead>
<tr>
<th>Dose</th>
<th>Patients who achieved EASI-75 response (%)</th>
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<tr>
<td>CIBINQO 100 mg</td>
<td>25.4</td>
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<td>CIBINQO 200 mg</td>
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<tr>
<td>dupilumab 300 mg</td>
<td>65.5</td>
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<tr>
<td>placebo</td>
<td>30.6</td>
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</table>

Early onset of treatment effect was seen in both doses of CIBINQO

Rapid and significant itch relief was seen as early as Week 2 vs. placebo as measured by PP-NRS4 (2° endpoint)³

Patients achieving a PP-NRS response with ≥4-point improvement from baseline

<table>
<thead>
<tr>
<th>Dose</th>
<th>Proportion achieving PP-NRS4 (%)</th>
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<tr>
<td>CIBINQO 100 mg</td>
<td>31.8%</td>
</tr>
<tr>
<td>CIBINQO 200 mg</td>
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<tr>
<td>dupilumab 300 mg</td>
<td>26.4%</td>
</tr>
<tr>
<td>placebo</td>
<td>13.8%</td>
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</tbody>
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Significantly more CIBINQO 200 mg patients achieved PP-NRS4 vs. dupilumab as early as Day 4 and remained higher through Week 2

CIBINQO is only indicated in patients who have had an inadequate response to other systemic drugs or for whom these treatments are not advisable. Over 50% of patients in these studies did not have prior exposure to systemic therapy.
Important safety information for CIBINQO

Clinical use
Can be used with or without medicated topical therapies for atopic dermatitis.

Limitations of use: use in combination with other JAK inhibitors, biologic immunomodulators, or potent immunosuppressants, such as methotrexate and cyclosporine, has not been studied and is not recommended.

Most serious warnings and precautions

Serious infections: patients may be at increased risk for developing serious bacterial, fungal, viral and opportunistic infections that may lead to hospitalization or death; more frequently reported serious infections were predominately viral. If a serious infection develops, interrupt treatment until the infection is controlled. Risks and benefits of treatment should be carefully considered prior to initiating therapy in patients with chronic or recurrent infection. Monitor for signs and symptoms of infection during and after treatment, including the possible development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy.

Malignancies: lymphoma and other malignancies were observed in patients taking JAK inhibitors to treat inflammatory conditions and were more frequently observed in patients with rheumatoid arthritis (RA) during a clinical trial with another JAK inhibitor versus TNF inhibitors.

Thrombosis: including deep venous thrombosis, pulmonary embolism, and arterial thrombosis have occurred in patients taking JAK inhibitors to treat inflammatory conditions. Many of these events were serious; some resulted in death. Consider risks and benefits prior to treating patients who may be at increased risk. In a clinical trial in patients ≥50 years of age with RA, a higher rate of all-cause mortality and thrombosis occurred in patients treated with another JAK inhibitor versus TNF inhibitors. Patients with symptoms of thrombosis should be promptly evaluated and treated appropriately.

Major adverse cardiovascular events (MACE): including non-fatal myocardial infarction, were observed more frequently in patients ≥50 years of age with RA during a clinical trial comparing another JAK inhibitor versus TNF inhibitors.

Other relevant warnings and precautions

- Driving or operating machinery
- Dose-dependent increase in blood lipid parameters, lipid monitoring and management
- Hematological abnormalities
- Use with potent immunosuppressants
- Vaccination
- Monitoring and laboratory tests
- Fertility
- Women of childbearing potential
- Pregnancy and breastfeeding
- Geriatrics

For more information
Consult the Product Monograph at http://pfizer.ca/pm/en/CIBINQO.pdf for important information regarding adverse reactions, drug interactions and dosing, which have not been discussed in this piece. The Product Monograph is also available by calling 1-800-463-6001.

References:

† Results from a phase 3 randomized, double-blind, placebo-controlled, double-dummy, parallel group, multicentre study of CIBINQO in combination with background medicated topical therapies in patients aged ≥18 years with moderate-to-severe atopic dermatitis who had an inadequate response to topical therapy or had received systemic therapy, excluding dupilumab. 2:2:2:1 randomization to CIBINQO 200 mg (n=226), CIBINQO 100 mg (n=238), dupilumab (n=243) or placebo (n=131) for 12 weeks. CIBINQO dose: 200 mg or 100 mg taken orally once daily. Dupilumab dose: 300 mg administered subcutaneously every other week after a loading dose of 600 mg at baseline. Matching placebo was dosed accordingly.
OneOMA at a glance

What is OneOMA?
The concept of OneOMA was introduced earlier this year to drive:

A member-centric culture
A focused, transparent, and strategic planning process
Continuous improvement to build an association members want, need and have pride in

The goal of OneOMA:
To strengthen the organization’s efforts to successfully come together to better serve members in four key areas of need:

Negotiations with government on physician compensation
Advocacy with government, the public and stakeholders to address health-system issues
Benefits of membership to meet the professional and personal needs of Ontario’s doctors
Leadership programs, education and opportunities for physicians who want to get involved

What will OneOMA mean to you?
More seamless experiences when dealing with the OMA:

- Easier access to all the programs, services and resources you need at each stage of your career
- A collection of products and services tailored to your needs that save you time and money
- More focused, transparent and strategic planning
- A unified and influential voice whether we’re talking to members, staff, the public, government or other stakeholders

Members will be updated on OneOMA as initiatives roll out over the coming months.
Let’s rebuild health care in Ontario together.

Building a better health-care system begins with advocacy.

Doctors play an important role in producing solutions and shaping health care in Ontario.

That’s why the OMA is looking for physicians – like you to join our health-care advocate program.

Scan this QR code and find out how to become an OMA health-care advocate.
Prioritizing solutions to Ontario’s primary care crisis

Chair of SGFP says key is getting doctors to work in their scope and removing administrative burden

by Keri Sweetman

A new Ontario Medical Association report sheds light on the province’s primary care crisis, with 2.2 million Ontarians unable to find a family physician.

Prescription Progress Report 2023 identifies three urgent areas for immediate attention: ensuring access to team-based primary care led by a family physician, reducing physician burnout and improving access to co-ordinated home- and community-based care.

It outlines the progress made on health-system transformation since the OMA launched Prescription for Ontario: Doctors’ 5-Point Plan for Better Health Care in 2021.

Dr. David Barber is chair of the OMA’s Section on General and Family Practice. He is an assistant professor in the Queen’s University Department of Family Medicine. We talked to him about the challenges in the primary care system.
Why is fixing the primary care system such an urgent priority?

DR. BARBER: Right now, in Ontario, we have 2.2 million patients without access to a family doctor and the repercussions of that are immense. We are in a system where the family doctor is the gatekeeper to other services and so, if there are no gatekeepers, then there’s no access to the system. As an example, right now in Kingston we had five doctors retire and so there are 8,000 patients who are all of a sudden left without a family doctor. There are no extra family doctors in Kingston. We have a single walk-in clinic, which is over-burdened. So, if a patient has, let’s say, diabetes and their control isn’t very good, they really have nowhere to go to get help. And they can’t see a specialist. Their option is to go to the emergency room, which is a real burden on them and not a good use of resources, or go to a walk-in clinic. But there are not enough walk-in clinics and that’s a fragmented model of care, to see a different doctor all the time.

The way out of this, in my opinion, is to get doctors to work at their scope. We’re doing a lot of things that aren’t really necessary at this stage. If we could take some of that stuff off our plates, through the use of other health professionals, then we could take on more patients and solve the issue of unattached to patients in Ontario. There are maybe a quarter of doctors who are part of these teams that have access to other types of professionals — physician assistants, nurse practitioners but also pharmacists, physiotherapists, dietitians who can help manage the patients.

We just need more resources so that we can take on these patients who don’t have a family doctor. That’s absolutely critical because we can’t just all of a sudden magically produce 2,000 family doctors, which is what it would take to look after 2.2 million patients.

Coming out of the pandemic, are family doctors seeing patients who are sicker because of deferred diagnostic tests and treatments?

DR. BARBER: We are seeing patients who are sicker physically and mentally. The mental health burden is extraordinary. When things get backed up in the system, that falls onto the family doctor’s plate, right? I have a patient who waited two years to see a rheumatologist for some aches and pains, which I thought was something serious going on. And so, for those two years, I’m looking after that patient, trying to do what I can to help them out. Mental health care is absolutely critical because we can’t just all of a sudden magically produce resources.

A recent OMA member survey found that 41 per cent of family physicians are considering retiring in the next five years. What are your colleagues telling you about burnout, and the administrative burden that is contributing to it?

DR. BARBER: We’re seeing the administrative burden increasing all the time. It’s estimated at about 19 hours a week (for family physicians) — that was from a study by the Ontario College of Family Physicians. That’s time that we can’t see patients, and I think when you take the joy out of it, that contributes to burnout. And the inability to provide your patients with top-level care, and needed care, it’s frustrating too. And as everything sort of comes together, family doctors just become less and less happy and they look at other options. I think that’s why you’re seeing that 41 per cent, saying, “I’m not enjoying this. I can’t really help my patients. It’s really stressful and I need to look at doing something else.” My own family doctor, he wakes up at four in the morning to start doing paperwork, every day, and a lot of people are working at night and working on weekends.

The number of medical students choosing to do residencies in family medicine continues to drop. What needs to happen to change that trajectory?

DR. BARBER: Medical students are seeing the practice of family medicine, and they’re looking at it when they’re exposed to it during med school, and they’re saying, “I don’t want to do that.” And the doctors who are teaching them are saying, “This is not fun and don’t go into family medicine.” So, I think that we’ve really failed in supporting family doctors. To make their ability to care for their patients a top priority. It should be one of the best jobs in the world, right? You’re helping people who are sick get better. When it’s at its best, it’s a very, very joyful profession.

What needs to happen is just to somehow take away that paperwork, the admin burden, a lot of the bureaucracy. Let family doctors be family doctors and see patients. That’s why we went into this – to look after patients. It should be one of the most attractive jobs in the world, in my opinion. So, it really is about resources. We need more resources. We need more people around us. There has to be more investment in the system alto-
Let family doctors be family doctors and see patients. That’s why we went into this — to look after patients. It should be one of the most attractive jobs in the world, in my opinion.

— Dr. David Barber

The crisis in primary care is happening across Ontario but it’s even more critical in northern Ontario. What can be done to encourage more doctors to practise in the north and to stay in the north?

DR. BARBER: The reality is, practising family medicine in the north is really, really stressful. People forget that in those communities, the community hospitals, the emergency room, obstetrics, everything is run by family doctors. Oftentimes, it’s remote and it’s hard to get locums to come in, and so how do you take holidays? How do you take that needed break? We need to look at different ways of incentivizing people, potentially expanding the education system there. But we have to create different models. We have to make that really unique and stressful type of practice more joyful for family doctors practising there because it’s unbelievable. I have so much respect for those physicians who do that really, really tough work.

Despite the current problems, are you optimistic about the future?

DR. BARBER: Yes, I am. The OMA is a really strong organization. We have a good relationship with the government. I think the government is open to the idea of more different types of models for providing family medicine to patients. And the reality is that we have the workforce to fix this problem, right? There are about 8,000 family doctors who provide cradle-to-grave care in Ontario. If we could provide them with more resources, with more people around them — then if each of them rostered 250 more patients, problem solved. Everybody has a family doctor.

So, there’s a solution that’s right in front of us that is going to take a bit of work, a bit of time and negotiation. But I don’t see why we can’t get there. And I do get the sense there’s an appetite.

I know that people are really hurting. I get people knocking on my door, my neighbors looking for a family doctor, asking me to be their family doctor or Uber drivers asking me, and it’s a real problem. So yes, we need to fix this. But I am hopeful we’ll get there.

This is an edited version of the interview with Dr. Barber

Keri Sweetman is an Edmonton, Alta.-based writer.
Past OMA presidents encourage others to lead advocacy for doctors

Challenging, yet important role, helped leaders deepen understanding of the association’s work

by Wendy McCann

In the first of a two-part series, the Ontario Medical Review takes a deeper look into the role of OMA president and the skills, sacrifices and stewardship needed to advocate on behalf of Ontario’s doctors.

Dr. Sohail Gandhi says a motto instilled in him by his grandfather, a guiding force throughout his life, was what propelled him to run for president of the Ontario Medical Association in 2018, a role he describes as an honour to hold.

“My grandfather, who is my hero, always told me that it’s one thing to speak out, but it’s another thing to actually get involved and work to fix a problem,” said Dr. Gandhi, OMA president from 2019 to 2020, and a rural family doctor in Stayner for more than three decades.

“Hearing those words, I decided that it wasn’t enough for me just to be critical of the path that I thought the OMA was taking us down...that I had to get involved and try and change things.”

Dr. Samantha Hill, a cardiac surgeon in Toronto, said she ran out of a sense of duty.

“I felt strongly, and I still feel strongly, that physicians, when brought together, are some of the most potentially powerful people in the world,” she said. “The majority of us are hard-working, smart and well-educated. We represent significant diversity — culture, origin, gender, previous experience, formative education, political leaning and more. If you bring all of these people together and unite them behind a common problem, what solutions couldn’t we find?”

Dr. Adam Kassam was a 32-year-old physiatrist when his peers encouraged him to put his name forward for president. They believed his youthfulness could bring a fresh vision to the OMA and help modernize the organization founded 140 years earlier. He threw his hat in the ring pre-COVID-19 and was appointed OMA president in 2021, as the pandemic roared on and doctors were charged with leading Ontarians through it.

“That obviously changed the way in which the leadership of the association had to react to the crisis and also changed how my role as president ended up being mostly remote,” Dr. Kassam said. “It also allowed us to bring together a common vision for the future, and also helping to try and support our membership who are at the front lines of the pandemic every single day.”

The OMA announces a new president each spring, following winter elections that are a key part of the organization’s democratic process. Those who are chosen spend a year as president-elect and have responsibilities as immediate past president in addition to their 12 months at the helm. They are fully supported by OMA staff, who provide briefings on issues and workshops in government and media relations.

Members are encouraged to put their name forward to help chart a path for the OMA and advocate on behalf of members.
It is just an incredible opportunity to make a difference, to advocate on behalf of your physician colleagues, to really insert the OMA into the health-care conversation in a meaningful way and ultimately make real progress for the lives of our physician members and also their patients.

Dr. Adam Kassam

Looking back on the experience, past presidents interviewed by the Ontario Medical Review agree on two things: One, while the role is challenging both in terms of making progress on issues and finding time to fulfill their responsibilities while also running their practice, it’s an important one. And two, it is a privilege to represent 43,000 doctors, even if, as Dr. Kassam said, “there’s a joke that you put five doctors in a room and you get six opinions, and you multiple that by 43,000, you can imagine the conversations that are had at various levels.”

The past presidents say the experience deepened their understanding of the OMA, their profession and the issues facing health care. They heard viewpoints from colleagues on how to improve the system which they perhaps hadn’t considered. They toured the province and saw first-hand the many ways doctors are caring for their patients, adapting health care to their own regions, settings and specialities. They saw behind the curtain of government, and learned more about how it operates, how to move an agenda forward and how to negotiate a deal.

“I was able to understand why we’ve had, quite frankly in some cases, so many roadblocks to trying to advocate for good patient care,” Dr. Gandhi said. “I was able to understand how we can work around some of those roadblocks to satisfy the needs of some of the bureaucrats to try and get us to where we want to be.”

Dr. Hill learned that even the easiest solutions require significant buy-in and hard work to achieve.

“It’s not just about what one wants or what one thinks the system needs. It’s about putting that into the greater context of all of our colleagues and our negotiating part-

Learn what it takes to be OMA president

PRESIDENT
The president acts as the OMA’s spokesperson on physician and professional matters for a 12-month period. This includes communicating to the public through the media, in promotions, on issues management, and at district meetings, industry events and conferences. As a voting board member, the president ensures an effective working relationship with the board chair, fellow board directors and the CEO. The president acts as a mentor and coach to the president-elect in co-operation with the immediate past president.

PRESIDENT-ELECT
The president-elect sits as an observer on the board of directors in preparation for taking on the role of president. During those 12 months, the president-elect learns all aspects of two roles: board director and OMA spokesperson.

IMMEDIATE PAST PRESIDENT
The OMA’s immediate past president sits for a 12-month period as an observer on the board and supports the board of directors with experience and knowledge gained in the role of president. They carry out the responsibilities and duties of the OMA president in the absence of both the president and the president-elect.
ners and trying to come up with a way forward that makes sense – not for 2022 or 2023, but for 2082 and 2083,” she said.

All three past presidents spoke with pride about their role in shepherding the massive modernization of the OMA’s governance structure and its leadership during the most challenging years of the pandemic.

They each came away from the experience with a renewed appreciation for the OMA.

Dr. Gandhi described himself as a member of the “rebel alliance” and one of the loudest critics of the OMA when he became president-elect. “And then when I got involved, one of the things I realized is that the staff of the OMA really do want to help physicians,” he said. “Where they really need our support as physicians is they need us to elect strong leaders.”

Dr. Hill said being part of the board and part of OMA operations, media activities, advocacy and policy-making opened her eyes to the breadth of activity that goes into supporting the work of doctors.

“These are people who are intensely devoted to their jobs and to physicians in Ontario, and every day they come in and bring 100 per cent. I saw people working through COVID. I saw people working through personal stress. I saw people working through the restructuring of the Ontario Medical Association. And through it all, I saw people who were excited and devoted. That’s something I’ll never forget,” she said.

They each have advice for anyone thinking of running for president.

“The first thing I would tell folks who are contemplating running to be president-elect is to do it. We need people who are engaged or energetic, who bring a new philosophy and vision for the future of the organization,” Dr. Kassam said.

“It is just an incredible opportunity to make a difference, to advocate on behalf of your physician colleagues, to really insert the OMA into the health-care conversation in a meaningful way and ultimately make real progress for the lives of our physician members and also their patients.”

Drs. Gandhi and Hill said anyone interested in the job should ask themselves why they want to do it.

“Do you want to do it because you want to make connections and improve your own personal careers and get yourself some consulting jobs? Then, don’t run and I won’t vote for you,” Dr. Gandhi said.

“On the other hand, if you’re sitting back saying, ‘Geez, you know we’ve got a great profession, but right now we’re under all this pressure. We’ve got some burnout issues, we’ve got some concerns about how we provide health care, we’ve got physicians who really need extra support to get the job done for the people of Ontario, and I think I can lend my voice to make that better,’ then I think you really should consider running.”

Said Dr. Hill: “For me, my why was always about the members. It was always about the idea that I didn’t have the answer, but that we as a group did. You need to know what your why is and you need to know exactly how much of yourself you’re prepared to devote to it.”

INTERESTED IN PUTTING YOUR NAME FORWARD FOR PRESIDENT-ELECT?
Scan the QR code to learn more about the upcoming nomination period leading up to OMA Elections.

NEXT ISSUE: The second of the two-part series will explore the impacts on practice and finances when seeking the role of president, and the other positions available across the OMA.

Wendy McCann is a North Bay, Ont.-based writer.

“I decided that it wasn’t enough for me just to be critical of the path that I thought the OMA was taking us down...that I had to get involved and try and change things.”

Dr. Sohail Gandhi
The Ontario Medical Association held its 143rd Annual General Meeting and Priority Leadership Group sessions in Windsor – District 1, from May 4 to 7. More than 250 members came together in-person and virtually over the four days, with representatives from across the OMA sharing experiences and discussions to work toward better health care for physicians and patients.

The AGM was a time of reflection and new beginnings. Immediate past president Dr. Rose Zacharias looked back on the achievements during her time as president, followed by the installation of Dr. Andrew Park as 2023-2024 OMA president who spoke about the opportunities that lay ahead.

Members also heard from Board Chair Dr. Cathy Faulds, who highlighted the importance of board transparency and CEO John Bozzo who spoke about the OMA’s ongoing efforts for health-care equity.

Delegates to the PLG attended various sessions over the weekend to prioritize the 2023 member ideas for each of the Advocacy, Issues and Policy and Compensation Panels. Delegates also discussed the OMA’s governance transformation and heard updates from PLG leaders and executives.

Members and staff also had the chance to engage in some social time.
OMA Annual General Meeting (May 4)

1 Dr. Andrew Park addresses the group for the first time as OMA president.

2 Dr. Cathy Faulds, OMA board chair, shares a board update to the hybrid gathering.

3 Clockwise from left to right: Dr. Veronica Legnini, chair, General Assembly Steering Committee; Sandy Zidaric, executive vice-president, OMA People and Culture; Dr. Hirotaka Yamashiro, vice-chair, Human Resources and Compensation Committee and Dr. Audrey Karlinsky, vice-chair, OMA Board of Directors participate in a panel discussion.

4 Dr. Jim Wright, executive vice-president, OMA Economics, Policy and Research (now retired) addresses the group at the AGM.

5 OMA member Dr. Shenaz Pabani takes her turn at the mic during the AGM panel discussion.

6 OMA immediate past president Dr. Rose Zacharias, right, welcomes OMA President Dr. Andrew Park and President-Elect Dr. Dominik Nowak, left, at the AGM.
1 From left to right: Dr. Chandi Chandrasena, chief medical officer, OntarioMD; Dr. Zainab Abdurrahman, OMA board director; Dr. Neil Isaac, PLG delegate; Dr. Sharon Bal, board director and Dr. Christine Tai, PLG delegate, share a smile at the PLG meeting.

2 Dr. Alykhan Abdullah, member-at-large, General Assembly Steering Committee, takes to the mic during the Q-and-A session of the PLG meeting.

3 PLG delegate Dr. Katherine McKay shares her ideas with attendees at the PLG meeting.

4 From left to right: Garth Oakes senior director, OMA Constituency Services; Dr. Cathy Mastrogiacomo, PLG delegate; Dr. Ted Mitchell, PLG delegate and David Collie, board director participate in the PLG discussion.

5 OMA members and staff come together at the Capitol Windsor Theatre for socializing and a movie.

6 Dr. Eric Goldszmidt, vice-chair, Compensation Panel, provides an update alongside Dr. Lisa Salamon, chair of the Advocacy Panel.
Physician Perspectives

If you had the chance to improve patient care in your specialty, what would you do and why?

Physician Perspectives is a regular feature in the Ontario Medical Review. Its purpose is to share differing points of view and inspire dialogue among members on important topics of the day. In this edition, we asked members at the OMA’s Priority and Leadership Group meeting in May about one thing they would change to improve patient care in their specialty, and why.

Dr. Alykhan Abdulla • family medicine – Ottawa

“I think the easiest way to move forward is to make sure that there’s enough of us around. In family medicine, we just need more people to have the time and the energy to look after people and move them through. I would triple the number of physicians that I have in my Family Health Organization, because for the same number of patients we would give them an incredible, improved quality of care.”

Dr. Ali Damji • family and addiction medicine – Mississauga

“Number one would be creating a centralized point for referrals. That’s one of the biggest pain points that I’m facing right now. At the system level, there’s a lot of challenges with health human resources and we don’t have a system that really prioritizes the resources that we have to ensure people are seen in a timely, most appropriate and efficient way possible.”

Dr. Joy Hataley • family medicine and anesthetist – Kingston

“We need creative new models immediately to serve patients who don’t have a family doctor. We need to create ways that they can access primary care outside of emergency departments and we need those now. Centres of care for unattached patients, where you don’t officially get a doctor, but you actually have a place that you can go get physician care and maintain your electronic medical record. Doctors would not be committing on a long-term basis to these patients, but would offer extra time that they can put into doing ad hoc care to help fill the care gap.”
Dr. Ted Mitchell - family medicine – Hagersville

“...The simple thing would be to almost eliminate these administrative duties and give doctors more agency. More control over how things are organized. I think I’ve seen in the last 20 years or so a decrease in control, more micromanagement from the (Ministry of Health) on down.”

Dr. Dannica Switzer - family medicine/rural generalist – Wawa, Algoma District

“...On a clinic day I usually have about four and a half hours of booked patient visits. And I also will spend two to three hours on non-patient-facing care. If the paperwork and the administrative burden could be done by someone who wasn’t me, in another two hours, I could see 50 per cent more patients. We’re not going to be able to bring 50 per cent more family doctors into this province anytime soon. But if we could reduce the amount of time they’re spending on non-patient-care tasks, we could effectively increase our family doctor workforce.”

Dr. Darija Vujosevic - family medicine – Niagara

“...I would like to have my own physician assistant in my practice. For me, physician assistants are perfectly aligned with the family doctor offices and they’re such a great addition. Every time I have a physician assistant, I feel happy, I feel relieved. How the family doctor trains the PA is as a mirror image of their practice and physician assistants really do want to play that role, supporting family doctors in direct and indirect patient care.”

Your stories matter and we want to tell them. The OMA wants to hear from you on the issues that impact and matter to you most.

Scan the QR code to submit a story idea.
District Dialogues

What challenges have been overcome in your community that benefited patient care?

District Dialogues is a new feature in the Ontario Medical Review aimed at spotlighting different perspectives on important health-care issues from physician leaders across Ontario. In this edition, the OMR asked representatives from each district about challenges they have had to overcome in their communities that ultimately benefited their patients and the health-care system.

OMA District 2 chair, primary care physician – London

In recent months, there have been substantial shifts in the delivery of care within our communities. The expansion of virtual care has enabled a convenient option for accessing necessary information for our patients. Additionally, it has enabled physicians to efficiently provide care to a greater number of patients within the same timeframe. Through collaborative efforts between our local OHTs and hospitals, a new working relationship has been established to address both individual patient care and population-based concerns.

OMA District 1 chair, family medicine – Windsor

My community struggled with a shortage of physicians in the region. However, since the establishment of the Windsor satellite campus of the Schulich School of Medicine and Dentistry, Western University, the Windsor-Essex area has seen a 35-per-cent increase in family physicians and a 31-per-cent increase in specialists in the area since its opening. The medical school also established a family medicine residency program. This program has been successful as 80 per cent of graduates from this program stay in Windsor-Essex. Also recognizing the severe shortage of psychiatrists in the region, a new psychiatry residency program was established by the school and has produced four graduates – three of whom have stayed in Windsor.

District 6 chair, family physician – Belleville

The COVID, Cold and Flu Care Clinics provided by Hastings Prince Edward Ontario Health Team are an example of just one initiative that helped ensure patients in my area got access to the right care, in the right place, at the right time. Hospitals in our area struggled to deal with the high number of patients suffering from COVID and cold symptoms, but these clinics were successful in diverting non-emergency traffic from emergency departments throughout the county. The clinics were also especially helpful for residents who are unattached, functionally attached, or unable to access their regular primary care.

No photo available
DR. SANDIP SENGUPTA

District 7, laboratory medicine – Kingston

“People living in rural southeastern Ontario lack access to rapid diagnostic interpretation of common blood abnormalities. A grant from Ontario Health allowed hospitals in this region to purchase new digital technology-based instruments that use specialized software to identify and classify abnormal cells on blood smears. This technology, implemented in Brockville, Perth, Smiths Falls and Napanee and electronically interfaced with the Kingston Health Sciences Centre, enables remote, real-time review of the blood abnormalities. Community hospitals that do not often see many patients presenting with hematologic abnormalities, such as malaria and leukemia, can now diagnose patients faster without needing to transport slides between hospitals.”

DR. RENATA VILLELA

District 5 secretary, Section on Psychiatry chair – Thornhill

“A significant challenge at the beginning of my practice was witnessing patients struggle with having to choose between engaging in mental health care and meeting other obligations, like work, school or childcare — especially those who lived further from city centres. With the expansion of virtual care options over the past several years, many logistical and geographic barriers have been overcome, which has led to more consistent psychiatric treatment. It’s been very rewarding being a part of this paradigm shift.”

Rotman Global Executive MBA for Healthcare and the Life Sciences

The OMA has partnered with Rotman School of Management at the University of Toronto to offer scholarships for the Rotman Global Executive MBA for Healthcare and the Life Sciences program. The GEMBA-HLS will provide the skills, knowledge and network OMA members need to drive transformative health-care system changes that benefit Ontario’s doctors and patients.

Rotman will offer up to five scholarship awards of $10,000 each for a total of $50,000.
Task force aims to solve pain points for HRM users

Increase in reports creating administrative backlog for physicians using EMRs

by Jamie Louie, OntarioMD

An influx of millions of reports each month from 500-plus sending sites through Health Report Manager has prompted OntarioMD and other health-system partners to unite and address this report management burden.

The HRM® tool has delivered electronic patient reports from hospitals and specialty clinics directly to more than 13,000 physicians’ electronic medical records for the past decade.

The HRM Experience Improvement Task Force – chaired by OntarioMD and including health-system partners such as the OMA, Ontario Health, the Ontario Hospital Association, hospitals, EMR vendors and Hospital Information System vendors – plays a key role in the electronic delivery of clinical reports from acute-care settings to community physicians.

Acknowledging physician calls for improvements, the task force is assessing report delivery issues to provide meaningful recommendations and identify solutions. Tackling these issues will help physicians spend less time on administrative tasks and documentation review, so they can focus more on patient care.

Here are the top four issues HRM users identified that contribute to administrative burden and are now under investigation by the HRM task force.
High volume of reports
There is no policy or standard to dictate which reports, transported easily through the HRM from an HIS, are sent to community-based physicians. Physicians, therefore, often receive all types of hospital reports, including a high volume of in-patient records and other reports not clinically relevant to patient files and risk missing critical patient-care information.

**ACTION:** Community-based physicians were asked which reports are necessary to inform a core report outlining recommendations for facilities, such as hospitals and specialty clinics. These reports were assessed by the task force and final recommendations were brought to health-system stakeholders, such as the College of Physicians and Surgeons, for their support.

Duplicate fax and electronic reports
Some hospitals still fax reports, in addition to sending them through HRM, duplicating the reports physicians receive. Doctors may also receive multiple electronic copies of the same report in draft and final form due to minor adjustments or delayed sign off. These upstream actions by hospitals also bog down inboxes and could compromise access to critical patient information.

**ACTION:** The task force is developing recommendations to address duplicate reports by reviewing HRM data, such as the number of reports delivered. Recommendations are expected by the end of the summer and will be reviewed by other stakeholders, including Ontario Health.

Lack of specificity in report categories
There are no guidelines for hospitals to follow to standardize report labelling in their HIS. Inconsistent report-naming across hospitals and other sending facilities makes it difficult for recipients, such as community-based physicians, to find relevant information quickly.

**ACTION:** The task force is finalizing its recommendations for consistent report-labelling using standardized naming conventions. For example, a provincial subset of Logical Observation Identifiers Names and Codes could be implemented across hospital sites. Recommendations will be shared and implemented once approved by OMD’s health-system partners.

Lengthy, unstandardized report formatting
There are no provincial standards addressing how content appears or is structured in reports, whether sent electronically or by fax. For example, reports delivered from hospitals using HRM are often several pages long with inconsistent formatting. Document length makes it challenging for physicians to quickly locate relevant patient information.

**ACTION:** The task force is examining how hospitals can ensure physicians find the most clinically relevant information in reports quickly through better formatting.

The HRM Task Force is finalizing its work and will publish a report in the fall. Reports will be available on the Task Force page of OMD’s website with updates provided in the Digital Health eTips newsletter. Sign up to receive eTips at OntarioMD.ca.
Value of Membership

This Value of Membership feature showcases the latest OMA developments, keeping members up-to-date on issues that matter most, including negotiations, physician leadership opportunities, administrative burnout support and more. This breakdown details all the OMA does to uplift Ontario’s doctors and advocate for health-care transformation.

Physician health and well-being

- The OMA’s Physician Health Program and Economics, Policy and Research division hosted the Beyond Burnout Conference on June 7 to discuss physician burnout
- The Ministry of Health-OMA Bilateral Burnout Task Force and the Forms Committee have engaged with the Canadian Life and Health Insurance Association. They have expressed interest in helping alleviate burden from insurance forms
- The OMA put forward a submission to the Ministry of Red Tape Reduction advocating for the reduction of red tape and administrative burden through addressing forms, centralized referral, electronic medical record integration, care co-ordinators and regional credentialling

Your membership organization at work

- The Negotiations Task Force engaged members and groups on their priorities for the 2024 Physician Services Agreement negotiations. Their feedback will help shape the mandate the NTF presents to the board in advance of bilateral negotiations
- The OMA’s Prescription Progress Report 2023 released in May, detailing actions taken by government to address 51 out of 87 recommendations laid out in Prescription for Ontario: Doctors’ 5-Point Plan for Better Health Care. The Progress Report outlines three urgent priorities: ensuring access to team-based primary care led by a family doctor, reducing physician burnout and addressing the lack of access to co-ordinated community care
- A June district and section leader orientation session provided attendees with information about communications and advocacy to support members in their OMA leadership roles
- The OMA’s Board of Directors approved three member-informed priorities selected by Priority and Leadership Group delegates. They are:
  o Compensation Panel: Allow physicians option to bill by time instead of fee code
  o Issues and Policy Panel: Prioritize initiatives to motivate recruitment of family physicians
  o Advocacy Panel: Enhanced access to physician-led multi-disciplinary care
Transformation and looking to the future

• The Ontario Medical Foundation website redesign makes it easier for members to support the foundation and contribute meaningfully to help advance health equity across the province
• The OMA member homepage was updated to be more user-friendly and include more member-centric content from across the OMA
• OMA Insurance is transitioning its group insurance program to Manulife Financial on Sept. 1. After extensive market research and in consultation with industry experts, OMA Insurance is confident that this change will continue to provide policyholders with best-in-class insurance products and services

Professional development and leadership opportunities

• The Ontario Medical Association, in partnership with the Rotman School of Business, is offering five $10,000 scholarships for physician leaders to obtain an MBA in Healthcare and Life Sciences. Participating physicians will be provided with skills, knowledge and a network that can help create health-care system changes that benefit Ontario’s doctors and patients
• The Ontario Medical Foundation received a donation of $150,000 from Dr.Bill, a premium medical billing solution, to fund research into systemic solutions that reduce barriers to equitable health care. The OMF divided the money into three grants for physicians conducting research and initiatives on solutions to physician burnout
• The OMA brought together more than 300 members during a hybrid event on OHIP billing for family doctors held in Ottawa to discuss virtual care codes, PSA-related billing changes and preventive care bonuses
• Physicians in the 2023 cohort of the Physician Leadership Program completed the second training module in May, which included lectures from health-care professionals on negotiating, storytelling, and health systems around the globe
IN MEMORIAM

The OMA would like to express condolences to the families and friends of the following members.

Abramson, Harry
North York
University of Toronto, 1954
January 2023 at age 92

Allan, Douglas James Moffat
Stratford
University of Edinburgh, Scotland, 1949
March 2023 at age 98

Apps, Robert Charles
Orangeville
University of Toronto, 1966
February 2023 at age 81

Baxter, Iain William M.
Parry Sound
University of Glasgow, Scotland, 1958
March 2023 at age 89

Bedell, John F.
Mississauga
English Conjoint Board, 1959
January 2023 at age 91

Behesnilian, Katyg
Toronto
Yerevan State Medical University, Armenia, 1977
November 2022 at age 72

Bhabha, Cassim Ahomed
Toronto
University of the Witwatersrand, South Africa, 1962
November 2022 at age 87

Birt, Anne Weymouth
Toronto
The University of London, 1958
October 2022 at age 89

Bogo, Norman Harvey
Toronto
McGill University, 1965
January 2023 at age 83

Brisson, Paul
Ottawa
University of Ottawa, 1970
March 2023 at age 76

Carscadden, Terence R.
Sudbury
Queen’s University, 1964
February 2023 at age 89

Chamia, Nabil Jean
Ottawa
Cairo University, Egypt, 1962
May 2022 at age 86

Charlton, Ronald William Roy
Scarborough
University of Toronto, 1958
October 2022 at age 91

Charters, James Ewart
Whitby
University of Toronto, 1954
March 2023 at age 95

Choudhuri, Satyam
North York
McMaster University, 2021
June 2022 at age 25

Cooper, Alfred Joseph
Timmons
University of Ottawa, 1958
January 2023 at age 91

Corbett, Shannon Lee
Mississauga
McMaster University, 2006
April 2023 at age 44

Costin, Thomas Blair M.
Burlington
University of Toronto, 1961
March 2023 at age 88

Dawood, Dawood Gorgui
Ottawa
Ain Shams University, Egypt, 1962
September 2022 at age 84

Dufour Jr, Thomas T.
Ottawa
University of Ottawa, 1964
December 2021 at age 82

Fenner, Danuta Z.
Toronto
Academy of Medicine Wroclaw, Poland, 1964
October 2022 at age 87

Fleming, Russel Leroy
Penetanguishene
University of Western Ontario, 1969
January 2023 at age 79

Florence, Ralph
Toronto
University of Toronto, 1955
December 2022 at age 92

Forget, Robert Jacques
Ottawa
University of Ottawa, 1967
January 2023 at age 83

Fowler, Peter John
London
University of Western Ontario, 1964
November 2022 at age 84

Furlong, F. Wayne
North York
University of Toronto, 1964
October 2022 at age 81

Goldstein, Stanley E.
Perth
McGill University, 1960
January 2023 at age 86

Gregorovich, Sandra
North York
University of Buenos Aires, Argentina, 1990
January 2023 at age 57

Harricharan, Cecil Edgar
Thornhill
Dalhousie University, 1958
May 2022 at age 93

Hope, Lily Anna
Hamilton
McGill University, 1969
November 2022 at age 79

Horky, Zdenek Anthony
Welland
Masaryk University, Czechia, 1956
January 2023 at age 91

Humble, Richard
Bracebridge
McMaster University, 1979
November 2022 at age 72

Irwin, Patricia Jane Scully
Long Sault
University of Toronto, 1955
September 2022 at age 91

Jaciw, George Andrew
Whitby
University of Ottawa, 1955
November 2022 at age 96

Johannsson, Peter William
Picton
University of Toronto, 1977
February 2023 at age 74

Jory, Thomas Arthur
London
University of Western Ontario, 1955
January 2023 at age 92

Kapoor, Anil
Hamilton
Dalhousie University, 1991
February 2023 at age 58
IN MEMORIAM

Kissick, James Stephen
Ottawa
Queen’s University, 1983
January 2023 at age 64

Lehan, Anne E.
Kitchener
McMaster University, 1986
March 2023 at age 66

Leon, Joseph Michael
Jerome
Welland
University of Ottawa, 1956
January 2023 at age 92

Leventhal, Joseph Isaac
Toronto
University of Toronto, 1950
February 2023 at age 102

Macaulay, Margaret Haf
Cornwall
University of Liverpool, England, 1955
October 2022 at age 92

Maxwell, Brian Edward
London
University of Saskatchewan
College of Medicine, 1963
September 2022 at age 99

McAlister, James J. A.
Hammer
University of Toronto, 1977
February 2023 at age 71

McAllister, Terrance Blake
Oshawa
University of Western Ontario, 1987
January 2023 at age 59

McLean, Juanita Arline G.
Toronto
University of Toronto, 1966
February 2023 at age 83

McPherson, Ewan Cameron
Huntsville
University of St. Andrews, Scotland, 1968
March 2023 at age 80

Napke, Edward
Ottawa
University of Toronto, 1951
February 2023 at age 99

Owen, John Graham Hughes
Oakville
December 2022 at age 94

Rapin, John Marc
Kingston
Queen’s University, 1969
April 2023 at age 77

Rayes, Wagdy Edward Amin
Apsley
Ain Shams University, 1965
February 2023 at age 80

Reesor, Helen Louise
Waterloo
University of Toronto, 1951
January 2023 at age 97

Richter, Ken
Montreal
McGill University, 1979
March 2023 at age 69

Russell, Alan L.
Brampton
University of London, England, 1963
February 2023 at age 85

Schwartz, Elliott Michael
North York
University of Toronto, 1973
October 2022 at age 73

Shaver, Jack Edward
Brantford
University of Western Ontario, 1955
September 2021 at age 90

Shimizu, Arthur George Shaw
St Catharines
University of Ottawa, 1959
November 2022 at age 95

Smart, John Edwin
Waterdown
University of Western Ontario, 1960
January 2023 at age 88

Smith, Frank Astor
Toronto
McGill University, 1964
November 2022 at age 85

Starr, Joseph Auby
North York
University of Toronto, 1964
November 2022 at age 81

Stephens, James Glenn
Waterloo
Schulich School of Medicine and Dentistry, 1952
April 2023 at age 95

Swinson, Richard Price
Hamilton
University of Liverpool, England, 1963
February 2023 at age 82

Taylor, George Oliver
Ottawa
University of Ottawa, 1955
April 2023 at age 96

Teal, Barbara Ann
Collingwood
McMaster University, 1983
February 2023 at age 65

Walters, William Ross
Neustadt
University of Toronto, 1955
September 2022 at age 92

Wang, David Wen-Shan
London
University of Dublin, Trinity College, Ireland, 1966
August 2022 at age 85

Westenberg, Hendrik Hans
Kingston
University of Amsterdam, Netherlands, 1961
January 2023 at age 86

Wisniowski, Leo E.
Chester Basin
Dalhousie University, 1991
January 2023 at age 57

Wojakowski, Krystyna H.
London
Academy of Medicine
Krakow, Poland, 1960
January 2023 at age 86

Wolfish, Norman Morton
Ottawa
University of Toronto, 1961
July 2022 at age 86

Yip, Lisa Y-Y ee
Waterloo
University of Western Ontario, 1994
March 2023 at age 53

The OMA publishes brief notices about deceased members as a service to their colleagues. Information concerning these members should be sent to info@oma.org. If you know a colleague or a relative of a deceased member who has practice-related questions and needs advice or would like an information package on closing a practice, please have them contact Practice Management and Education at 1.800.268.7215 or practicemanagement@oma.org.

In Memoriam online allows family and friends of Ontario physicians honour their memory and legacy.

Find out more at: www.oma.org/in-memoriam
Your Hearing Deserves An Audiologist

Audiologists’ Role in Tinnitus Management

- Audiologists are regulated health professionals who assess and treat tinnitus.
- Tinnitus is the perception of sound in the absence of an external source. It affects millions of people worldwide and can have a profound impact on one’s quality of life.
- While there is no cure for tinnitus, audiologists can provide a range of evidence-based interventions to help manage and reduce the severity of symptoms. These may include sound therapy, counseling, and cognitive behavioral therapy.
- It is important for physicians to refer patients with tinnitus to audiologists for a comprehensive hearing evaluation, as well as to rule out any underlying medical conditions that may be contributing to their symptoms.
- Finally, it is worth noting that tinnitus is often a comorbidity of other conditions such as hearing loss, anxiety, and depression. Therefore, addressing these comorbidities through a multidisciplinary team approach can significantly improve patient outcomes.

Understanding the value of partnering with audiologists in diagnosing and treating patients with tinnitus, physicians can help ensure that their patients receive the most comprehensive and effective treatment possible.

References:
Waldemar Narozny MD. PhD1, Dmitry Tretiakow MD. PhD1, and Andrzej Skorek MD. PhD, Tinnitus in COVID-19 Pandemic, Ear, Nose & Throat Journal 2021, Vol.100(3S)197S–198S
https://www150.statcan.gc.ca/n1/pub/82-003-x/2019003/article/00001-eng.htm

WHO WE ARE
OAPAC is a group of independent audiologists who own and manage audiology clinics throughout the province of Ontario.

WHAT WE DO
- Audiologists are leaders in hearing health and auditory disorders.
- Audiologists have either a Masters or Doctorate degree in Audiology.
- Audiologists must use evidence-based practice principles and follow best practices. Your patients will be met with safe, quality, ethical care that meets professional standards and guidelines.
- Audiologists assess, identify, and manage all individuals – adults and children – with peripheral or central hearing loss, tinnitus, hyperacusis and balance disorders.
- Audiologists select, prescribe, fit and dispense hearing aids and other assistive listening devices.
- Reminder: Hearing aids cannot be dispensed without a prescription!
- Audiologists provide advanced testing which may include: Speech-In-Noise testing, Auditory Processing testing, Electrophysiological tests (e.g. ABR, OAEs), Cognitive Screening and/or Vestibular Assessments.
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Email: jfthor@hotmail.com

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