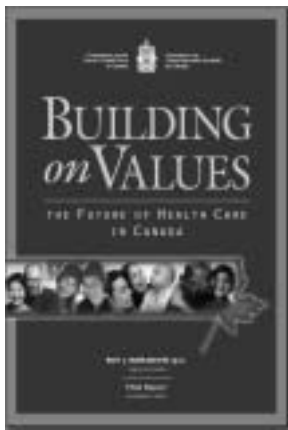


## In tow with Romanow

by Joseph Mikhael, MD, FRCPC

Since Mr. Romanow was first commissioned by the government to review the status of health care in Canada, we have been involved. As both PAIRO and as CAIR, we have been working very hard to ensure that the voice of residents is heard. We made several presentations to him, including the visit to St. Mike's emerg at midnight.



He presented his report to Parliament on November 28th, and we were there.

It is a 400 page report and it is impossible give you all of the details. In summary, he calls for renewed federal funding to enhance our publicly funded, universally accessible health care system. On the physician resource front, he specifically proposes a special fund for incentives for rural and remote medical practice, and enhanced funding for rural and remote training initiatives.

Indeed, Romanow specifically singles out PAIRO's work with communities in Ontario to improve physician distribution, noting that we represent the "new face of medicine", and "a new generation of physicians that is more open to working in a diversity of locations and models of health care delivery."

## New Resident Placement Program dates announced!

*Need assistance finding a home for your career? Entry to practice information? Locum tips? The PAIRO Resident Placement Program is here to help. We will be visiting your centre on the following dates:*

Thunder Bay: January 11/12, 2003  
McMaster: January 15/16, 2003  
Western: February 4, 2003  
Toronto: February 19/20, 2003  
Ottawa: February 24, 2003  
Kingston: February 25, 2003

Please call Charlotte Kirby at 1-877-979-1183 or you can email her at [charlotte\\_kirby@pairo.org](mailto:charlotte_kirby@pairo.org) to set up an appointment.

**Note: If you are unable to attend on the scheduled day, a telephone interview can be done at your convenience.**

December 2002

Romanow's report supports primary care reform and alternate practice systems (that includes working with other health care professionals such as nurse practitioners). He also recommends increased funding for technology, a healthcare monitoring council to ensure provincial accountability, and increased support for rural medicine.

With "new docs working for medicare" and "open to change" as our mottos, we have been reiterating our commitment to a strong, renewed publicly-funded health care system, and our familiarity with working in a team model of health care delivery.

In general, we support Mr. Romanow's recommendations, however, we are concerned that Romanow did not appreciate the severity of the physician shortage in Canada, nor did he recognize the need for enhanced support for teaching hospitals and the adverse effects of escalating and excessive tuition fees. We have responded with several initiatives to voice our views, both in the press and meeting with politicians and stakeholders who will be influential in the implementation of the Romanow Report.

As Canada's new doctors, we have the most at stake. We will inherit the system, and will be providing care for the next 40 years. It is critical, therefore, that we use this opportunity for the benefit of our patients and our members.

Find more RPP info on page 6 of this issue!

# ▶ Latest WACCC initiatives

The Workload and Contract Compliance Committee (WACCC) is taking measures to uphold and

enforce the call scheduling parameters in the PAIRO-OCOTH Agreement. Specifically, we have begun the first stage of a province-wide educational mail-out aimed at reminding program directors about call schedule limitations, the new home by noon for home call and vacation/professional leave entitlements and requirements. One of our main goals this year is

to encourage programs to clean up their call schedules by including simple, but often overlooked information, such as hospital, program and "in house/at home" call identification. In order to try and clear up these absences we have drawn up a very general

call schedule template and included it in the mail-out with the hope that programs will either use it or refer to it when drawing up their own schedules.

The vacation reminder is timely because we are quickly approaching the February 15th resident deadline for submitting vacation requests. Residents who are taking certification exams in the Spring are exempt from the February 15th deadline for one of their four weeks of vacation, but still obliged to submit their request four (4) weeks prior to their requested vacation date. We want to remind the programs that they cannot make blanket denials for vacation on their service.

The mail-out to programs will be complimented by a poster campaign in the New Year that aims to help inform and enforce the home by noon provision. Our hope is that this campaign will not only encourage residents already entitled to go home by noon post call, but to also support the new contract clause dealing specifically with "home at noon for home call". This clause states that "The

right to go home by noon is now clarified to extend expressly to home call in some circumstances. This applies where the resident called in to the hospital commences work after midnight, but before 6 am, or works at least four consecutive hours one of which is after midnight." It is also important to recognize that one cannot be post-call when starting the five (5) days off between Christmas and New Years. These five (5) consecutive days are to be a span of twenty-four (24) hours each. Collectively, these efforts should contribute to a more restful, enjoyable and satisfying year for Ontario's residents.

## Contract Capsule

### Computer Data Entry

Residents will not normally be required to enter, co-sign orders or enter other data into a computer, in addition to being required to enter, or co-sign such orders or enter such other data in a handwritten version.

## A moment in PAIRO history

### 1999: Bart Maeves Resolution

On November 25th, 1999 PAIRO successfully defeated Bill 95, which stated, "If the government's current initiatives fail to correct the doctor distribution problem throughout Ontario, then the government should proclaim sections of the Savings and Restructuring Act, 1996 allowing it to attach geographic to all billing numbers issued by the Ministry of Health".

## Committees at a glance

### Committee on Resident Education (CORE):

Chairs: Joseph Mikhael, Hasan Zaidi

### Community Physician Resource and Health Policy Development:

Chairs: André Michon, Eileen deVilla, Tammy Leon

### PAIRO Communications and Member Benefits Committee:

*The newly created Communications and Member Benefits Committee will work to enhance communication with membership via Progress Notes and the PAIRO website. This committee will also be responsible for all future reviews and enhancements of benefits such as Long Term Disability, etc.*

### Resident Well-Being Committee:

Chairs: Laura Musselman, Heather MacDonnell

### Workload and Contract Compliance Committee (WACCC):

Chairs: Kevin Lefebvre, Geoff Hung

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*Your comments and submissions are always welcome. Please send them to:*

[progressnotes@paipro.org](mailto:progressnotes@paipro.org)

# President's message

## Limited licensure and residents

It comes up in member surveys. We get asked about it on site visits. We get dozens of emails and phone calls about it. It used to be commonplace. It ended for most residents in Ontario with the elimination of the rotating internship. It is often still called moonlighting.

I believe there is a way that residents can work outside the confines of their program. It is called limited licensure.

It is not for everybody, and clearly requires certain limitations (hence the term "limited"). But in a day of physician resource shortages for Ontarians, and skyrocketing tuition, it can both provide needed medical care, and help pay the bills. When residents want other clinical exposure, it can be provided. When residents are not overwhelmed by their current clinical duties, they should have the choice.

Ontario is the only province outside of Quebec that prohibits it. The other provinces have found a way to make it feasible for residents, beneficial to and safe for patient care, and agreeable to by educators.

We haven't that same luxury. But not because we haven't tried. PAIRO has raised this issue countless times, and has sought support from Deans, the CPSO, the government, hospitals, and even the communities. I can confidently say we have done everything in our power to make limited licensure a reality. However, despite various times of opportunity, the door remains closed. Ironically, at a time when the door is being opened up to IMGs because of the physician shortage

crisis, qualified residents in Ontario training programs are being denied the opportunity to provide their services.

The main reason for this is opposition from the Deans. In fact, I believe it is fair to say that if the Deans were not so opposed, we would have limited licensure in Ontario. As a result, I have decided to include in the newsletter a copy of a letter sent from the Deans to the Minister of Health. It disturbs me - not so much because of its content (the Deans have the right to oppose limited licensure - even though I believe some of their logic to be faulty), but the fact that we were not even copied on it. More importantly, it will give residents a clear sense of the position of the Deans on an issue which you have consistently indicated is a priority for you. We believe that you should know where the Deans stand on this.

We have been open about our views and our desire about limited

licensure. We want to work with the Deans, not against them. I have also included our response to the letter, including earlier letters we have written which address the Dean's concerns. We will not give up. You have asked us not to.

We are committed to quality education for residents in Ontario, and don't wish anything to interfere with it. In a collegial, professional and comprehensive manner, this issue can be openly discussed and, we believe, resolved, in a manner no different than in the rest of Canada.

Joe

[joseph\\_mikhael@paipro.org](mailto:joseph_mikhael@paipro.org)

Click here to read the letters referred to in this article.

## Ending the confusion: moonlighting vs limited licensure

### Moonlighting

Moonlighting residents are those who have achieved certification in a specialty (from either the RCPSC or the CFPC) and have been granted an independent practice license. There is no restriction on these residents providing these extra clinical services. The article in this newsletter is not in reference to this practice.

### Restricted/Limited/Graduated Licensure

Residents who have achieved an identified amount of training providing extra clinical services under "defined licensure". This is currently permissible for residents represented by all other provincial housestaff organizations in CAIR, in various forms. Under the current regulations, Ontario residents are prohibited from providing this service, no matter what their qualifications to do so.

# The changing model in disability insurance for the professional

By John Sealey, CFP, CLU, CH.F.C., RHU, FLMI

Change is inevitable, and as a medical professional, you know this better than anyone. Advances in pharmaceuticals, new technologies and ongoing research continuously challenge our perceptions and force us to consider new alternatives.

The same is true for the insurance industry. Mortality table assumptions have been challenged with the advent of AIDS. E-commerce, as a new distribution network, allows you to compare your current coverages to those offered by other companies and even purchase insurance on-line.

In the disability income (DI) insurance marketplace, there has been considerable consolidation of insurance companies, leaving us with fewer choices when purchasing disability insurance. Are there alternatives to a dwindling pool of DI providers?

## Alternatives

The OMA offers disability insurance to its members through what

is known as an association group policy. Association group policies differ in a number of ways from the contracts offered by individual insurers. It is these differences, when added to the aggressive sales pitch from commissioned individual DI sales-

people, that make it difficult for even the insurance professional, let alone the medical professional, to separate fact from fiction.

## Differences - Fact or Fiction?

It is important to understand that an individual DI salesperson has no choice but to promote individual disability insurance policies to members of the medical profession; they simply do not have access to the association's product. Coverages available through the association are offered directly by the association, which eliminates the need to pay sales commissions, and reduces the cost of insurance to the membership.

Individual DI insurers and salespeople promote "non-cancelable and guaranteed renewable" contracts, which means that the contract's premium and provisions cannot be changed until the insured reaches age 65, and therein lies the main point of differentiation between individual DI contracts and association group contracts. Premiums and insuring provisions are not guaranteed under an association group contract. Under the OMA contract, plan changes require the approval of both the insurer and the OMA, and only the OMA has the right to cancel the contract. Is this, as many individual DI salespeople would have you believe, a bad thing?

Not in the right hands. Take an experienced insurer, quality association insurance management, steady, high income membership, and you have the formula for providing superior benefits at a great price.

## Pricing an Individual Disability Insurance Contract

When pricing disability insurance, there are three variables to consider: interest rates; administration costs; and the frequency and duration of claims.

Consider the mechanics of offering a financial product, such as an individual DI contract, with both price and policy provisions that could not be changed for roughly forty years or longer. The insurer will have to assume a very low rate of interest, very high claims incidence and very high administrative expenses. To underprice any of these components is to lose money, so it is imperative to build in a margin of safety. As well, a profit must be priced in over and above these very conservative estimates.

What happens if, despite all forecasting, things were worse than expected? The insurer can't change the premiums of all those previously issued guaranteed policies. The only option is to charge more for new policies to make up for the shortfall. As well, if you're like most people, you will purchase additional amounts of disability insurance as your income increases during the course of your practice. You'll be picking up the tab to cover this shortfall several times over.

And what happens in the event that interest rates, administrative expenses and claims costs are better than expected? The additional profit goes directly to the insurer's bottom line.

**John Sealey is a principal in Sealey/Manning Inc., an independent consulting firm working in the disability insurance marketplace. A former Marketing Director of the Canadian Bar Insurance Association, John has been involved in plan design, marketing and, most recently, with disability claimant assistance in the Canadian Insurance industry.**

## Association Group Disability Insurance Pricing

Acting on behalf of its insured members, the association works with the insurer and agrees to reasonable premium rates based on the coverage offered. If circumstances were to change dramatically, rather than have the plan lose money, the association would work with the insurer to fine tune the plan, through rate adjustments or provision changes, to bring it back to a revenue neutral position.

Why is this approach better than a guaranteed contract? The individual guaranteed policy insurer has to assume the worst case scenario when pricing its policy, and passes on these assumptions to its policyholders. On the other hand, the association and its insurer can use reasonable estimates and realistic assumptions when it comes to interest rates, administrative expenses and morbidity. An association can also take over many of the administrative functions of an insurer, making for a lower premium requirement.

What happens if the association group's experience is better than

anticipated? Surplus can be credited back to the plan. Reserves can be strengthened, or premiums can be refunded to the insured members. In the OMA's case, over the last ten years, the disability plan has averaged a premium refund of 25% to its insured members, and refunds have been paid out every year since the inception of the plan.

### Flexibility is the Key

The association plan's policy wordings are flexible, and can change to address the challenges faced by physicians. Association group contracts are ideally suited to respond to the changing environment. Changes in how the medical profession operates can be reflected in changes to the provisions of the association group's contract. These changes can be made automatically to all existing coverages as well as new coverages.

In the last year alone, the OMA has added a Partial Disability benefit to its Professional Overhead Expense policy and has extended coverage under that plan to age 80 from its previous termination age of 70. The current reality is that doctors are working beyond

age 70, and while they may have their retirement income arranged and no longer need income protection, they still need disability insurance to cover their overhead expenses in the event they become disabled. The OMA responded to this reality by making the appropriate changes to the contract. Individual disability contracts don't have that flexibility.

Change is inevitable, - so why buy a disability insurance contract whose principal selling point is that it never will? The association group insurance model is far better suited to addressing the needs of the medical profession, both now and in the future. Why settle for less?

### *The Essentials Program*

*Essentials* is a unique offer endorsed by PAIRO to provide qualified members of PAIRO with access to Disability, Professional Office Overhead Expense and Life insurance through the OMA *without being required to provide evidence of good health.*

If you would like additional information regarding the *Essentials* program, contact the OMA Insurance Services department at 416-340-2918 or 1-800-268-7215, ext. 2918. You can also e-mail [insurance\\_services@oma.org](mailto:insurance_services@oma.org). Details of the insurance plans available under the *Essentials* program are also available at [www.OMAinsurance.com](http://www.OMAinsurance.com).



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When you need help...

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toll free

## HELPLINE

1 866 HELP DOC

*100% confidential and anonymous  
All calls are answered by Distress Centre  
volunteers who are from non-medical  
backgrounds and not affiliated with  
PAIRO or any universities*

# Things to think about before your Resident Placement Program interview

You see the light at the end of the tunnel, and so you finally booked it - your RPP interview. Now that you've made that big step, is there anything you need to do to prep? Fear not, the interview process is pretty casual, more of a consultation, but here is a list of things that you may want to consider beforehand:

- o What type of position are you looking for? Permanent? Locum?
- o What would you like included in your practice? For example: ER shifts, Academics, Obstetrics, Surgical Assists, Consultations, Office. Is there anything that you would not like included?

- o Where do you want to go? Northwest Ontario, Northeast Ontario, Central, Southeast Ontario, Southwest Ontario, or do you have a specific community in mind?

- o What size of community would you like to work in? A rural or remote community? A small urban center, or a larger one?

- o Have you signed a Return of Service agreement with the Ministry of Health and Long-Term Care?

- o What kind of practice would you like to work in? A solo or small/large group practice?

- o Do you require any special equipment or facilities?

- o Do you have a partner and will he/she be seeking employment as well?

- o Do you have special family needs?
- o Do you have any hobbies or interests that may influence your decision on where to practice?

Even if you are unsure of what you're looking for you can be sure that you will be given lots of information which will help you with some of these decisions.

You may also want to do a bit of research in advance on the PAIRO Registry website at [www.pairoregistry.com](http://www.pairoregistry.com). Click on "Doctors seeking community" and you can search for positions either by type, community size, geographic location, etc. or you can research a specific community.

If you would like more information or would like to book an interview, be sure to contact Charlotte Kirby at [charlotte\\_kirby@pairo.org](mailto:charlotte_kirby@pairo.org), or via telephone at 1 877 979-1183.

## Thanks to Ontario CDOs!

PAIRO would like to take this opportunity to thank Ontario's Community Development Officers (CDOs), who are responsible for the recruitment and retention efforts in the five regions of the province, for their on-going support and assistance of the PAIRO Resident Placement Program.

### Northeast Ontario

Ms. Jackie Thoms, Ms. Johanne Labonte  
[www.nomec.on.ca](http://www.nomec.on.ca)

### Northwest Ontario

Ms. Joanne Lacourcière  
[www.hscn.on.ca](http://www.hscn.on.ca)

### South Central Ontario

Ms. Michelle Hunter  
[www.romponline.com](http://www.romponline.com)

### Southeast Ontario

Mr. Bruce Maitland  
[www.cdoseo.com](http://www.cdoseo.com)

### Southwest Ontario

Ms. Laurie Roberts  
[www.cdosworm.com](http://www.cdosworm.com)

## Find a Home for your Career.



Connecting New Doctors and Communities

Contact us for an interview at:  
1-877-979-1183 or [rpp@pairo.org](mailto:rpp@pairo.org),  
[www.pairo.org](http://www.pairo.org)



COUNCIL OF  
ONTARIO FACULTIES  
OF MEDICINE

An affiliate of the Council of Ontario Universities

September 26, 2002

Honourable Tony Clement  
Minister of Health and Long-term Care  
10th Floor, Hepburn Block  
80 Grosvenor Street  
Toronto, M7A 2C4

Dear Minister:

**Re: Resident Moonlighting**

The Deans and Postgraduate Deans of the Council of Ontario Faculties of Medicine (COFM) have reviewed the matter of resident moonlighting. We define moonlighting as residents providing clinical services outside of a residency education program for remuneration.

Resident moonlighting concerns us for the following reasons:

- **Patient Safety and Resident Well-being** – COFM has fought hand-in-hand with the Professional Association of Interns and Residents of Ontario (PAIRO) to establish the current learning environment, in which hospitals, Program Directors and teaching faculty are more respectful of a resident's need for a humane work schedule.

There has been progressive improvement in the working conditions of residents over the course of many years, with reduction in on-call schedules, early departures the day after a night on call, improved vacation and conference provisions, and other measures to make the residency experience more fulfilling and positive. A key step occurred only three years ago when PAIRO successfully negotiated a reduction in call from 1 in 3 nights to 1 in 4.

Having well-rested residents safeguards patient safety and promotes quality, non-sleep-deprived time for residents to study, do their reading, research, etc. There is growing data to show the negative effects of sleep deprivation on patient care. The US group that accredits the nation's teaching hospitals is in the process of imposing strict new limits on the number of hours worked by residents. While Canadian residency programs have more humane work schedules than our US counterparts, the concerns are the same in that these rules are intended to reduce the risk of dangerous errors by sleep-deprived young doctors.

- **Divisiveness Amongst Residents** - While there is the occasional high flyer that can cope with moonlighting while in training, many residents do not have the capability or time and are unable to take advantage of this financial avenue, creating tensions between residents in the same program. Residents on research leaves from their training programs should not be relied on for service

180 Dundas Street West, Suite 1100, Toronto, Ontario M5G 1Z8 416 979-2165 Fax 416 979-8635

E-mail [cou@coupo.cou.on.ca](mailto:cou@coupo.cou.on.ca) Web Site [www.cou.on.ca](http://www.cou.on.ca)

provision. They do not have any less onerous requirements placed upon them than those actively engaged in postgraduate training.

- Supervision - Postgraduate training is a transition to independence, all levels requiring appropriate supervision. Every rotation has learning objectives and an evaluation component, and is supervised in accordance with the fundamental principle of clinical education – graded responsibility. If supervision was not required, i.e. residents were ready for independent licensure, then residency programs would end sooner. Program Directors oversee the supervision of all residents in their program. If moonlighting were to be permitted, Program Directors do not wish to have responsibility for deciding who can or can't moonlight, or for overseeing such activity.
- Finances - Moonlighting is financially driven. We do not support PAIRO's argument that, on the one hand, a 1 in 4 call schedule is needed for patient safety and resident well-being reasons, yet on the other hand, a 1 in 3 or 1 in 2 schedule is acceptable for financial reasons. If PAIRO believes that adjustments in resident compensation are needed, then fairness suggests that these adjustments be negotiated in the usual fashion and be applicable to all residents.

We are acutely aware of the shortage of physician services in the province and are working in partnership with your government to find appropriate short and long-term solutions. However, we are concerned that moonlighting is actually a destabilizing approach to regional shortfalls in human resources, one that may undermine local continuity of care, have retrogressive effects on our residency programs, and distract from the more constructive and sustainable solutions that are already under active discussion with the Ministry. We look forward to a continuing partnership with your government as regards the latter solutions.

Sincerely,



David Walker, MD, FRCPC  
Chair

cc: Dr. Rocco Gerace, College of Physicians and Surgeons of Ontario  
Mr. Mike McCarthy, Minister's Office  
Mr. George Zegarac, Ministry of Health and Long-term Care  
Ms. Diane McArthur, Ministry of Health and Long-term Care  
Ms. Caroline Abrahams, Ministry of Health and Long-term Care  
COFM Deans  
Postgraduate Deans

PAIRO

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December 12, 2002

David Walker, MD, FRCP(C)  
Chair, Council of Ontario Faculties of Medicine  
1100 - 180 Dundas Street West  
Toronto, ON  
M5G 1Z8

Dear Dean Walker:

Re: Resident Moonlighting Letter to Minister Clement Dated September 26, 2002

As you know, the Professional Association of Internes and Residents of Ontario and the Council of Ontario Faculties of Medicine have worked together on many issues in a cordial and open manner.

In light of this, we are concerned to have only recently found out about your letter of September 26, 2002 to Minister Clement addressing the issue of "Resident Moonlighting". This letter specifically dealt with an issue of great importance to our members. PAIRO was repeatedly referenced in the letter. The letter was also copied to five people within the Ministry, the College of Physicians and Surgeons of Ontario and approximately ten people within COFM. Despite this we were never given a copy of the letter nor were we even informed of its existence, regardless of its wide circulation to all other stakeholders.

Although we respect your opinions and your right to communicate them, we are disappointed at being denied the simple courtesy and respect of receiving a copy of your letter that repeatedly referred to PAIRO.

Furthermore, according to the minutes of the November University of Toronto PGMEAC meeting, we understand that this letter was in response to a meeting we had with the Minister to discuss this issue. In fact, we did not have such a meeting. This further underscores the sequelae of poor communication; had you expressed your concerns to us, this frustration could have been avoided. This is disappointing as we have always discussed this issue in a transparent manner.

As the representative body of the approximately 2500 residents within Ontario, we hope that we will not continue to be excluded from an issue that is of primary importance to the medical residents of Ontario

Dean Walker  
December 12, 2002  
Page 2.

As to the content of your letter, we have responded previously to the concerns you express, and in that regard, enclose a copy of our letters of September, 1998 and May, 1999 to the CPSO, which addressed the concerns you have raised in your September, 26 letter.

As always, would like to discuss this matter, and more importantly, the whole question of resident licensure, with you. We anticipate your response.

Sincerely,

Joseph R. Mikhael, MD, FRCP(C)  
President

Encls.

- c. Dr. Rocco Gerace, CPSO  
Mr. Mike McCarthy, Minister's Office  
Mr. George Zegarac, Ministry of Health and Long-term Care  
Ms. Diane McArthur, Ministry of Health and Long-term Care  
Ms. Caroline Abrahams, Ministry of Health and Long-term Care  
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Postgraduate Deans

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May 20, 1999

Dr. R. Gerace, Chair  
CPSO  
80 College Street  
Toronto, Ontario  
M5G 2E2

Dr. Helen Gordon  
CPSO  
80 College Street  
Toronto, Ontario  
M5G 2E2

Dr. R. Sanders  
CPSO  
80 College Street  
Toronto, Ontario  
M5G 2E2

Dear Drs. Gerace, Gordon and Sanders:

**Re: Proposal to Steering Committee on Restricted Registration**

On behalf of PAIRO I would like to submit this proposal for restricted registration for senior postgraduate trainees.

Postgraduate trainees in both CFPC and RCPSC training programs have highly developed skills and knowledge which allow them to function at increasing levels of independence during the course of their residency training programs. At more senior levels, residents provide relatively independent medical care, with supervision/back-up available at an appropriate level.

There are a number of important advantages to society as a whole as well as to residents in allowing residents to provide care in settings beyond their current training programs. First, the ability to work in different types of medical settings provides residents with different professional exposure. This adds to the breadth of the residents' education and experience obviously assisting her/him in their professional development but ultimately society as a whole will obtain the benefit of physicians with wider experience. Second, previous experience in Ontario, coupled with that from other provinces and countries demonstrates that residents exposed to rural communities during their training are much more likely to establish practice there. Thus, broadening exposure during training will improve recruitment to underserved communities in Ontario.

A third factor is that residents have been actively involved in the challenge of assisting underserved communities to find appropriate medical services. We believe that residents can help to provide a part of the solution if we are permitted the opportunity to assist, in appropriately supervised settings, to deliver critically needed care. Fourth, there is an obvious need for additional services from trainees in teaching hospitals. As the number of postgraduate trainees has shrunk, some teaching hospitals have paid residents cash to provide additional care, for example in the intensive care unit (ICU) while doing research rotations. While regulations should not be changed just because they are not being complied with, the fact that they are not being complied with demonstrates that there is an important need that is not being met and which is forcing senior and responsible institutions to respond. Restricted registration would regularize this essential work.

Finally, residents are increasingly older during their training than in the past, often training well into their thirties with spouses and children to support. Restricted registration would enable

residents in these situations not only to provide needed care but also to mitigate the financial hardship of increasing undergraduate medical tuition, the imposition of tuition fees for postgraduate training and the growing duration of training.

As you know, prior to the licensure changes of 1993, residents received a general license to practice medicine after completing a rotating internship. They would then either begin independent practice or return for further residency training in either RCPSC or CFPC programs. During these further years of training, many residents worked extra shifts outside their residency training programs covering hospital wards, emergency departments and provided locum tenens coverage. PAIRO believes that there should be appropriate rules so that any changes in the licensure regime do not lead to independent practice; however, with appropriate rules residents could provide badly needed services in appropriate settings.

PAIRO recognizes that in determining whether such opportunities should be granted it is a paramount concern to ensure that the public is protected and that appropriate medical care is always provided. PAIRO shares that commitment with the CPSO. In this regard ensuring that residents who provide services under restricted registration have the skills necessary to do the work would be addressed in two ways. First, residents would be licensed only to work in areas where they have received sufficient and appropriate training. Second, residents would only be able to provide care outside their training programs where they have appropriate supervision, support and back-up as may be necessary.

With respect to the existing responsibilities of residents in their programs, it should be noted that the CPSO has never purported to regulate or to restrict what residents, or other physicians for that matter, do outside their regular employment. Limitations on the maximum hours of work and service which can be required of residents by hospitals are intended to provide reasonable limits on service provision, and time away from work for teaching hospitals can reasonably be devoted to other activities at the option of the resident. It must also be remembered that on call duties tend to be onerous in the early part of residency training. During the senior years, call requirements are usually more relaxed and these individuals are likely able to provide services under restricted registration.

In summary, establishing a mechanism for residents to provide services in certain settings outside of their training programs would be advantageous to the public of Ontario, the medical profession and residents themselves. This approach is consistent with the growing recognition across Canada that some form of restricted registration can enhance the services provided to citizens and communities. Five provinces have implemented rules similar to what we propose and included with our proposal.

PAIRO would be pleased to discuss this matter with you and to address any questions or concerns that you may have.

Sincerely yours,

Amir Janmohamed, MB, BS, FRCPC  
President

Encl.

PAIRO

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September 14, 1998

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Toronto, Ontario  
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Dear Drs. Kraftcheck and Bonn:

**Re: Graduated Licensure for Residents**

We understand that the CPSO is in the process of reviewing its approach to residents in CFPC and RCPSC training programs providing services outside the normal requirements of their training programs. In particular, there is considerable need in both urban teaching hospitals rural, and underserved area hospitals and clinics for qualified residents to provide call, locum tenens and related services.

As you know, prior to the licensure changes of 1993, residents received a general license to practise medicine after completing a rotating internship. They would then either begin practising medicine, or return for further training in a specialty - either CFPC or RCPSC. During these further years of training, many residents worked extra shifts outside of their residency training programs. They covered hospital wards, emergency departments and provided locum tenens coverage. The Ontario Physician Manpower Data Bank reported that in 1985, 12% of residents in Ontario billed OHIP in a professional capacity.

However, with the licensure changes, the availability of this locum tenens pool has essentially vanished, as the cohort of residents who obtained their independent practise licenses from a rotating internship is virtually gone. As a result, there is now an increasing shortage of available physicians to provide call, locum and related medical services. In PAIRO's view this situation has arisen despite there being a cohort of highly trained medical practitioners who are willing to provide medical care.

In this context, PAIRO brings the following proposal forward in the interests of the public, medical facilities needing staff, and our members.

Postgraduate trainees in both CFPC and RCPSC training programs have highly developed skills, and function at increasing levels of independence during the course of their residency training programs. At more senior levels, residents provide relatively independent medical care, with supervision/back-up available at an appropriate level where necessary.

Currently in Canada, there are five provinces which license residents who have completed sufficient training to provide medical service outside of their training programs. In Saskatchewan, eligible residents are licensed to provide locum tenens coverage in a Saskatchewan hospital. In Nova Scotia, New Brunswick and Prince Edward Island, residents may receive a license to practise in particular areas of medicine - with specific requirements

for providing certain services i.e., emergency department coverage. The license is available to second year CFPC trainees and trainees in the final two years of RCPSC designated specialties. In Newfoundland, residents can provide GP coverage in early years of residency training, and specialty specific coverage in the final years. All of these arrangements have a level of supervision and monitoring in place which is acceptable to the provincial medical licensing authority. Further details of these arrangements are provided in Appendix A.

In these provinces, and historically in Ontario, licensing residents to provide additional medical services in certain settings is a clear benefit to communities and patients, the medical profession and to residents themselves.

Moreover, there is a clear and demonstrated need for residents to provide call and locum services. This is evidenced by the requests from various urban-based hospital programs for residents to provide call coverage with appropriate compensation. There has been an increase in the number of urban teaching hospitals interested in hiring residents to cover shifts they are unable to staff. Hospitals are seeking to have residents cover services where they have trained and demonstrated competence. Indeed, there are already various programs where residents are providing such services, enabled in part through the delegation provisions of the RHPA.

As well, rural and northern communities in Ontario are having difficulties covering their emergency departments or hospital wards. Most recently, the situation in Wallaceburg has brought this to public attention. Through our work with Ontario communities, we are aware of many other communities who are asking for the residents who used to provide them with vital care and give their established physicians locum coverage for holidays and continuing medical education leave. They were pleased with the care they received in the past from these residents. They also know that smaller communities are more successful in recruiting and retaining physicians if they have previously trained/practised in their community. Most recently, the Thames Valley District Health Council discussion paper on current issues affecting rural physicians explicitly proposed reinstatement of licensing medical residents for communities with acute shortages of physicians. As well, there are now an increasing number of rural and northern sites with recognized preceptors, who could provide support and back-up to residents providing call and locum coverage, where necessary.

The established medical profession has had tremendous difficulty in solving even basic aspects of the underserved area challenge. This includes basic care for all Ontarians and back-up and relief so rural doctors can take vacation or CME leave. PAIRO has been very active in this area, and it is clear to us that the medical profession as a whole, as well as communities and patients, would benefit from having a locum tenens pool of residents. The fact is that residents are needed to cover the often unattractive shifts available for locum tenens.

Residents are interested in being able to provide extra care beyond their training programs for several reasons. First, the ability to work in different types of medical settings provides residents with different professional exposure. This adds to the breadth of resident education and experience. As mentioned above, this has led in the past to residents choosing to practise in rural communities, thereby improving recruitment of physicians to underserved areas. Second, residents have been actively involved in working on the challenge of underserved communities in Ontario. We feel that we can help to provide a part of the solution if we are permitted the opportunity to provide at least some of the needed locum and call coverage. Last, residents are increasingly older during their training than in the past, often training well into their thirties, with spouses and children to support. They are also facing significantly increasing costs for medical education and thus high debt loads. For all of these reasons, we propose expanding opportunities for residents to provide medical service outside of their training programs. We recognize that the CPSO will be concerned to ensure that the public is protected and appropriate medical care is provided. The first and foremost issue is whether the residents who may be eligible to provide locum coverage actually have the skills necessary to do the work. This point is addressed in two ways. First, residents would only be permitted to work in areas where they have received sufficient training. Second, residents would only be eligible to provide these additional services where they have appropriate support and back-up, as necessary.

Another concern the CPSO may have relates to resident workload. When considering these concerns, one often envisions the majority of residents working excessive amounts of call all the time. However, while current contract provisions set call maximums at one night in three, there is a great variation in the frequency of call in different residency programs. In addition, call tends to be most onerous in the early part of residency training.

Moreover, there is a fundamental difference between providing residents with an option to use their personal time to work and a mandate from a program demanding work. Residents are capable of evaluating their personal situation and deciding whether they would like to use some of their time to provide call or locum coverage. This is, of course, the same decision process a resident would undergo regarding how to use his or her personal time in other ways, i.e. family life, recreational activities, community work, etc. Quite frankly, training programs have no say in whether a resident participates in these activities, unless it *begins to interfere* with a resident's training. This principle applies equally to residents providing services outside their training programs. In any event, residency programs have mechanisms in place to monitor residents who are not meeting the expectations of their programs and patient care.

In summary, establishing a mechanism for residents to provide services in certain settings outside of their training programs would be advantageous to the public of Ontario, the medical profession and residents themselves. Moreover, there are precedents in five Canadian provinces at the current time which support this approach.

There are various legal mechanisms for addressing this issue. For example, there could be an expansion of the current educational license, a 'graduated' or 'defined' license, or delegation under the RHPA. However, in general, we believe that the following template contains the key features which could be incorporated into any of these approaches.

Sincerely,

Amir Janmohamed, MB, BS, FRCP(C)  
President