DISCIPLINE COMMITTEE OF THE
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

BETWEEN:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

-and-

ROLAND CHEE KONG WONG

-and-

INCOME SECURITY ADVOCACY CENTRE

Intervenor

WRITTEN SUBMISSION
Of the Intervenor, the Income Security Advocacy Centre

PART ONE: OVERVIEW

1. Physicians who fill out Special Diet Allowance application forms are performing an important social function. For their patients, the Special Diet Allowance means access to food that they need in order to treat chronic medical conditions. For some, the Special Diet Allowance can be necessary for their very survival. Without this benefit, Ontario Works ("OW") and Ontario Disability Support Program ("ODSP") recipients cannot afford the special diets recommended by their doctors.

2. The Special Diet Allowance is only one of many social benefits that can only be accessed with supporting evidence from a medical professional. For this reason, the manner in which this Honourable Panel elaborates the standard of practice will inevitably have a broader impact.

3. With this broader impact in mind, the submission of the Income Security Advocacy Centre (ISAC) will do two things. First, in keeping with ISAC's public interest standing, this submission will set out some contextual factors that are relevant to determining the appropriate standard of practice for physicians completing social benefit applications. Second, this submission will address the public interest principles that should be taken into consideration in order to ensure that the standard of practice assures access to social benefits that improve health.

PART TWO: CONTEXTUAL OVERVIEW

4. The central feature of OW and ODSP is that these are considered programs of "last resort" with extremely low monthly benefits. A single person on OW receives a maximum monthly benefit of $599. A single person on ODSP receives a maximum of $1,064 per month. In order to be eligible, recipients must have virtually no assets, nor any other significant sources of income.

Ontario Works Regulation, O. Reg. 134/98, ss. 41(1), 42(1).

Ontario Disability Support Program Regulation, O. Reg. 222/98, ss. 30(1), 31(2).

5. Social assistance incomes fall well below the poverty line, by any of the established measures. As a result, social assistance recipients experience great difficulty in accessing healthy food. Moreover, any expenses outside the ordinary grind of every day life will deepen their already existing financial crisis. Nutrition is often sacrificed when harsh choices must be made between paying the rent and buying food.

Medical Officer of Health (November 3, 2009), "The Affordability of the Nutritious Food Basket in Toronto – 2009" (Toronto Board of Health), Exhibit G to the Affidavit of Mary Marrone, pp. 211-212, 214.

Testimony of Valerie Tarasuk, March 20, 2012.

6. This state of extreme poverty, without access to healthy food, is an important contextual factor for this Honourable Panel to consider for two reasons. First, because poverty has significant repercussions for health and second, poor health associated with poverty increases the importance of access to the Special Diet Allowance as a medical intervention.

i. Poverty is a major determinant of poor health

7. There is a clear link between poverty and poor health. People living on low incomes consistently have higher rates of morbidity and mortality due to chronic and acute illness. The correlation between poor health and poverty is even greater for those receiving ODSP, as for many recipients it is precisely their poor health that has qualified them for the ODSP benefit. Thus, the population of people who are eligible to apply for the Special Diet Allowance is already at a higher risk for poor health than the general population.

Medical Officer of Health (November 3, 2009), "The Affordability of the Nutritious Food Basket in Toronto – 2009" (Toronto Board of Health), Exhibit G to the Affidavit of Mary Marrone at p. 213.

Gary Bloch, Linda Rozmovits, Broden Giambrone (2011), "Barriers to primary care responsiveness to poverty as a risk factor for health" (BMC Family Practice 2011, 12:62), Exhibit H to the Affidavit of Mary Marrone at p. 229.

8. Dr. Bloom, an expert witnesses called by the College, acknowledged that poverty is an important determinant of health. He also acknowledged that the amount of funding provided through OW and ODSP makes it challenging to provide many of the necessities of life, including meeting nutritional needs. The other expert witness called by the College, Dr. Lake, agreed that there has been a concern that poor nutrition associated with low social assistance rates has a health impact.

Exhibit 18: Report of Dr. Bloom, p. 3.

Transcript of evidence of Dr. Bloom (December 7, 2011) at p. 4A-6, 11.

Transcript of evidence of Dr. Lake (December 6, 2011) at p. 3A-7, 8.

9. Low income households consume fewer fruits, vegetables, dairy products and fibre, and consume more high energy dense foods. Poor access to healthy foods is linked to diabetes and cardiovascular disease, amongst other conditions.

Medical Officer of Health (November 3, 2009), "The Affordability of the Nutritious Food Basket in Toronto – 2009" (Toronto Board of Health), Exhibit G to the Affidavit of Mary Marrone at p. 213.

10. Even among low-income populations, there are sub-populations at even greater risk. For example, the prevalence of chronic health conditions and poor health is greater for households living in rural areas, for visible minorities and for Aboriginal people.

Alice Nabalamba and Wayne J. Millar (2007), "Going to the doctor" (Statistics Canada), Exhibit K to the Affidavit of Mary Marrone at p. 251-252.

11. In light of the low income available to OW and ODSP recipients, and the already poor health of many ODSP recipients, it is not surprising that 20% of all social assistance recipients receive the Special Diet Allowance.

Exhibit 20: Community Services Audit Service Team (September 2010), "Forensic Audit of the Special Diet Allowance Program" (Toronto: Ministry of Finance) at p. 1.

12. The health impact of poverty is particularly significant for children, because of the lifelong impact it can have. Children growing up in poverty have a higher risk of detrimental health outcomes throughout their lives, even if their socio-economic status improves later in life.

> Gary Bloch, Linda Rozmovits, Broden Giambrone (2011), "Barriers to primary care responsiveness to poverty as a risk factor for health" (BMC Family Practice 2011, 12:62), Exhibit H to the Affidavit of Mary Marrone at p. 229.

13. The potentially harsh outcomes for poor children are particularly applicable in this proceeding because six of the 15 patient records that are before this Honourable Panel belong to children.

> Exhibit 6: Patient Records, SDA Forms and OHIP Records for Fifteen (15) Patients, see Tabs 1, 2, 3, 6, 8, 11.

ii. The Special Diet Allowance is an important health intervention

14. The Special Diet Allowance provides additional money to OW and ODSP recipients who have confirmation from a health professional that they suffer from one or more of the medical conditions listed in the Regulation. The conditions included in the Regulation are those for which there is general recognition in the Ontario medical community that a special diet is required. In order to be included in the Regulation, the special diet must also cost more than a regular healthy diet.

> *O. Reg 222/98*, s. 30(1)(4) (General Regulation to the *Ontario Disability Support Program Act*, S.O. 1997, c 25, Sch B).
>
> *O. Reg 562/05*, Schedule 1 (Prescribed Regulation to the *Ontario Disability Support Program Act*, S.O. 1997, c 25, Sch B).
>
> *O. Reg 134/98*, s. 41(1)(4) (General Regulation to the *Ontario Works Act*, S.O. 1997, c 25, Sch. A).
>
> *O. Reg 564/05*, Schedule 1 (Prescribed Regulation to the *Ontario Works Act*, S.O. 1997, c 25, Sch. A).
>
> *Ball v. Ontario*, 2010 HRTO 360, Exhibit A to the Affidavit of Mary Marrone.

15. Access to the Special Diet Allowance for people with health problems is crucial for maintaining health. For example, the Special Diet Allowance provides additional funding for a diabetic diet, in order to ensure that diabetic recipients can increase their servings of fruits, vegetables, fibre and whole grains; have access to low fat options; and, decrease sugars. For

diabetics, a special diet is essential for controlling their disease. Without a special diet, diabetics become sicker, and there are increased costs to the health care system as a whole.

> Special Diets Expert Review Committee (April 2008), Final Report, Exhibit B to the Affidavit of Mary Marrone at p. 102.

16. Despite the critical importance of the Special Diet Allowance for health, it is not a generous program. A panel of experts retained by the Ministry of Community and Social Services ("the Ministry") itself criticized the program for significantly underfunding some medical conditions. It took litigation to force the Ministry to implement its expert panel's recommendations, with the Human Rights Tribunal finding that the program discriminated against recipients with hypertension, hyperlipidemia, hypercholesterolemia and extreme obesity. There are numerous other conditions that remain to be litigated.

> *Ball v. Ontario*, 2010 HRTO 360, Exhibit A to the Affidavit of Mary Marrone.
>
> Special Diets Expert Review Committee Final Report (April 2008), Exhibit B to the Affidavit of Mary Marrone.

17. Thus for many conditions, the allowance provides far too little. The allowance is, nonetheless, an important ameliorative health intervention.

18. This context is important. There has been a tendency in this proceeding to focus upon the possibility that there were people receiving the allowance who did not qualify, and a corresponding desire to ensure that the standard of practice should preclude this possibility. However, from a public health perspective the flip side is of far greater concern: the standard of practice should ensure that those who are eligible for the allowance receive it.

19. These concerns are not unique to the Special Diet Allowance. Physicians are the gatekeepers to a number of social benefits that are necessary for the survival and well-being of many low-income disabled persons. There are numerous social assistance benefits and programs that can only be accessed by way of forms completed by medical professionals, such as the Canada Pension Plan (Disability), Workplace Safety and Insurance benefits, and ODSP itself.

20. Access to these benefits can drastically increase the quality of life and health for some of Ontario's most vulnerable people. As is argued below, having access to a physician who is prepared to complete social benefit applications in a timely and comprehensive manner is absolutely essential for the health of many impoverished Ontarians.

PART THREE: THE STANDARD OF PRACTICE

21. On their face, the application forms that Dr. Wong completed were fairly straightforward. The forms included a list of all of the conditions eligible at that time. The health professional completing the form was required to check off the conditions that applied to the particular patient before them, and then sign the form to confirm that the patient had the medical condition(s) and required a special diet.

> See, for example, Exhibit 6: Patient Records, SDA Forms and OHIP Records for Fifteen (15) Patients.

22. This proceeding has heard evidence from various physicians who disagree in respect of whether these forms are simple or difficult to complete. It is clear that they were intended to be simple. The forms were approved by the Ontario Medical Association (OMA) prior to implementation, pursuant to a Memorandum of Agreement between the Ontario Medical Association and the Ontario government. The Agreement provides that "every reasonable effort" will be made "to reduce the amount of administrative work being done by physicians in order to increase patient access to care" [emphasis added].

> Ontario Medical Association and HMQ in Right of Ontario, "Memorandum of Agreement", Clause 17.1, Exhibit F to Affidavit of Mary Marrone.
>
> *Ball v. Ontario*, 2010 HRTO 360, Exhibit A to the Affidavit of Mary Marrone at para. 27.

23. Nonetheless, the forms have not been without problems or controversy. For example, although "unintended weight loss" has been on the form since 2005, it was not until August 2011 that the Ministry issued a clarification about when a patient is eligible for an unintended weight loss allowance. The "clarification" provides for a more generous interpretation of eligibility than might be apparent by reading the words on the form alone. It confirms that current weight loss is not required, so long as the patient had lost weight in the past due to an eligible condition, and so long as the patient requires a special diet in order to maintain their weight. In other words, the purpose of a Special Diet Allowance can be preventive. As noted by several witnesses, there are

other conditions on the form that are open to various reasonable interpretations, such as chronic constipation.[1]

> MCSS (August 2, 2011), "Changes to the Special Diet Allowance: Supplementary Questions and Answers for Health Care Professionals", Exhibit E to the Affidavit of Mary Marrone.

24. ISAC agrees with the OMA and the Ministry that reducing administrative work and increasing access to patient care are salutary goals. As shall be argued below, ensuring that social benefit forms in general are simple and straightforward to complete is consistent with access to these important health benefits. This goal should not be undermined by the imposition of medically unnecessary or complex requirements imposed by the College of Physicians and Surgeons of Ontario.

25. ISAC takes no position on what the standard of practice for completing social benefit forms should be, nor does ISAC take a position on Dr. Wong's conduct. ISAC's interest is in ensuring that the perspectives of the patients are considered by this Honourable Panel. In putting forward that perspective, ISAC highlights a series of principles that we say should guide this Panel, in order to ensure that the standard of practice for completing social benefit forms is one that will allow both the College and physicians to fulfill their role in promoting the health and well-being of the public.

Principle One: The standard of practice should not be a barrier to access

26. Access to benefits such as the Special Diet Allowance can drastically increase the quality of life and health for some of Ontario's most vulnerable people. However, there are a number of barriers that can make it difficult for low-income Ontarians to access medical professionals to complete social benefit application forms.

27. The first and most obvious barrier is the lack of access to a regular doctor. In Ontario, 9.2% of residents do not have access to a regular doctor. This rate varies according to location, with some areas of the province experiencing sharper shortages of doctors than others. Dr.

[1] Note that "chronic constipation" was removed from the Special Diet Allowance Regulation in April 2011. See the current versions of *O. Reg 564/05*, Schedule 1 (Prescribed Regulation to the *Ontario Works Act*, S.O. 1997, c 25, Sch. A). *O. Reg 562/05*, Schedule 1 (Prescribed Regulation to the *Ontario Disability Support Program Act*, S.O. 1997, c 25, Sch B).

Bloom testified that south-west Toronto is an area with a shortage of doctors. However, a decision in this proceeding will affect physicians across the province. In some areas, particularly in the north and east, access to a regular primary care provider can be very difficult, even more so for accessing specialists.

Statistics Canada (2010), "Access to a regular medical doctor, 2010", Exhibit I to the Affidavit of Mary Marrone, pp. 237-238.

Statistics Canada, "Regular Medical Doctor 2007/2008", Exhibit J to the Affidavit of Mary Marrone.

Testimony of Dr. Bloom (December 7, 2011) at p. 4A-11.

28. Dr. Wong testified that groups that came to him for help included homeless people, women's shelters, mental health groups, Native Residence and poverty groups. He testified that many of the patients that he saw claimed to have no family doctor. This is consistent with the mounting evidence of inequitable access to a regular doctor based on factors such as income, race and gender. Indeed, both Dr. Lake and Dr. Bloom agreed that people on welfare would have more difficulty accessing family doctors than the general population.

Testimony of Dr. Wong, December 8, 2011 at p. 5A-22, 60.

Alice Nabalamba and Wayne J. Millar (2007), "Going to the doctor" (Statistics Canada), Exhibit K to the Affidavit of Mary Marrone at p. 256.

Testimony of Dr. Lake (December 6, 2011) at p. 3A-5.

29. The majority of patients without a regular doctor rely on walk-in clinics and emergency rooms for medical care. Dr. Bloom believed that poor people in general and people on welfare specifically would access emergency rooms more than the general population. A significant segment of the population with mental health and addictions use the emergency room for conditions that could well be dealt with in an ambulatory setting. Dr. Bloom observed that mental health and addictions often go hand-in-hand with financial instability.

Statistics Canada (2010), "Access to a regular medical doctor, 2010", Exhibit I to the Affidavit of Mary Marrone, p. 238.

Testimony of Dr. Bloom (December 7, 2011) at p. 4A-13, 14.

30. Over and above simple access to a regular doctor, low-income people face numerous other practical barriers to accessing high quality primary care. These include: lack of access to transportation; not having a valid health insurance card; inflexible practice rules and billing structures that make it disadvantageous for family physicians to serve patients with complex care

needs. Patients may also be reluctant to seek help due to stigma and shame at personal circumstances, low literacy levels, substance abuse issues and cognitive impairment.

> Gary Bloch, Linda Ozmovits and Broden Giambrone (2011), "Barriers to primary care responsiveness to poverty as a risk factor for health" (BMC Family Practice 2011, 12:62), Exhibit H to the Affidavit of Mary Marrone at pp. 230-231.

31. When patients living in poverty access health services, they are more likely to have shorter consultation times than their wealthier peers, and are less likely to be involved in treatment decisions. Unfortunately, unwelcoming attitudes or disrespect towards low-income patients and discrimination by family physicians based on ethnicity, immigration status, and gender, in conjunction with low income, may also constitute a barrier to care.

> Gary Bloch, Linda Ozmovits and Broden Giambrone (2011), "Barriers to primary care responsiveness to poverty as a risk factor for health" (BMC Family Practice 2011, 12:62), Exhibit H to the Affidavit of Mary Marrone at pp. 230-231.

32. If the standard of care established in this proceeding has the effect of limiting form completion to a regular clinical setting, many low-income Ontarians will be denied access to social benefits that can improve their health, as these are the very people who are least likely to have a regular doctor. The already existing disadvantage faced by such communities would be deepened.

Principle Two: Social Benefit administrators must be able to rely upon forms completed by doctors

33. Whatever the standard is, it must be one that will allow social benefit administrators to rely upon the opinion of physicians. Social assistance recipients are not well-served by a process in which administrators view medical opinions – and applicants – with distrust.

34. This should not be taken to mean that physicians must engage in medically unnecessary testing in order to corroborate each and every condition on the Special Diet Allowance application forms. The Special Diet Allowance forms require a physician to "confirm" a medical condition, not to "corroborate" it. This is an important distinction.

35. Some of the expert evidence submitted in this proceeding could be taken to suggest that independent corroboration is required in every case. For example, in a report prepared for this proceeding. Dr. Lake opined that Dr. Wong displayed a lack of proper diligence, "such as a full assessment with history and physical, former medical records, laboratory testing, or consultation notes, which would corroborate the self report."

Exhibit 3: Report of Dr. Lake, p. 6.

36. This view would set a highly onerous standard, and could be taken to require a physician to order laboratory testing or send a patient to a specialist in circumstances that were medically unnecessary. It could also cause significant hardship for the patient, who may have to wait lengthy periods for testing to be completed or to obtain a specialist appointment. Medically unnecessary testing would increase costs for the health care system, and negatively impact access for patients who actually have a medical need.

37. However, in testifying before this Honourable Panel, Dr. Lake clarified the steps he felt were required to complete the forms. Dr. Lake acknowledged that filling out a form could be based on the patient's own information with proper questioning, for example asking what medications they are taking or what happens when they eat eggs, and other appropriate questions. If he was unsure, Dr. Lake stated he would give the patient the benefit of the doubt.

Testimony of Dr. Lake (December 6, 2011) at p. 3A-26, 34.

38. The standard of practice should not change simply because a physician has been asked to complete a form that will result in payment of a government benefit. Nor should physicians be required to approach their patients with suspicion simply because they are a low income person seeking a social benefit. Dr. Berger observed repeatedly that doctors do not work for the state and that their allegiance is to their patients.

Testimony of Dr. Berger (March 26, 2012).

39. The same diagnostic criteria applied to any other patient in similar circumstances should be used. For example, where a patient history and/or evidence of a prescription is normally sufficient to diagnose a condition and treat with a special diet, this reasonable history should be sufficient for a physician to give the necessary confirmation on the Special Diet Allowance form.

Social benefit administrators should be confident in relying upon forms completed to such a standard.

Principle Three: Poor people are entitled to the same quality of health care as everyone else, including a right to have social benefit forms completed

40. While this principle may seem obvious, it bears repeating. Nothing in this submission should be taken to detract from a basic commitment to equality and principled care for low income people in Ontario.

41. In light of the significance of poverty as a determinant of health, it is critical that physicians in Ontario acknowledge that issues such as inadequate income fall within the duty of care of family physicians. Social benefit application forms are not simply administrative paperwork, or a nuisance detracting from clinical practice. Primary health care providers must consider and address income as a distinct risk to health and they should support social benefits, such as the Special Diet Allowance, <u>as an important part of treatment</u>.

> Gary Bloch, Linda Rozmovits, Broden Giambrone (2011), "Barriers to primary care responsiveness to poverty as a risk factor for health" (BMC Family Practice 2011, 12:62), Exhibit H to the affidavit of Mary Marrone at p. 232-233.

42. Any chilling effect on a physician's willingness to complete social benefit application forms could exacerbate the already existing problem of the denial of benefits to Ontario's most vulnerable populations. For example, the imposition of a burden upon physicians to conduct medically unnecessary testing could cause physicians to avoid or refuse to complete these types of applications forms. Fear of discipline could also cause physicians to refuse to complete social benefit application forms.

43. Concerns of a chilling effect are increased if there is no corresponding obligation on physicians to complete forms for their patients or to assist individuals who do not otherwise have access to family physicians.

44. This proceeding is an appropriate case to not only establish a standard of practice to guide the professional completion of social benefit forms, but also to highlight to the profession its obligation to do so.

45. Professional standards in respect of the completion of social benefit application forms should not compromise access to social benefits. If discipline can flow from the manner in which social benefits forms are completed, corresponding guidance should be given in respect of a physician's positive obligations to complete the forms. If there is no obligation upon physicians to complete forms for their patients, vulnerable and impoverished Ontarians will be disadvantaged in accessing social benefits that they require for their very survival.

46. People living in poverty are entitled to the same quality of health care as anyone else – including a right to treatment by having social benefit forms completed when appropriate.

PART FOUR: CONCLUSION

47. In its motion to participate in this hearing, ISAC raised concerns about the potential negative consequences for patients if the bar was set too high. Having the benefit of the conflicting opinions presented through expert evidence, these concerns remain.

48. The experience of the ODSP application forms can assist this Honourable Panel in understanding the potential impact if the completion of Special Diet Allowance forms was limited to a regular health care provider with a requirement for corroborating evidence in all cases.

49. The Commission for the Review of Social Assistance notes that "applying for ODSP can be a challenging process because of the detailed medical records and application forms required." Several of the medical witnesses in this proceeding made reference to the ODSP application form, in order to contrast the requirements of that application form to the Special Diet Allowance application. According to these witnesses, the ODSP form requires a physician to have done a complete assessment of a patient, with corresponding laboratory and specialist

reports. The forms are lengthier and require an assessment not only of medical conditions but also functional capacity.

Testimony of Dr. Lake (December 6, 2011).

Testimony of Dr. Bloom (December 7, 2011) at p. 4A 46-48.

Commission for the Review of Social Assistance in Ontario (June 2011), "A Discussion Paper: Issues and Ideas", Exhibit L to the Affidavit of Mary Marrone, p. 266.

50. The evidence is clear that these more onerous requirements pose a significant barrier in accessing ODSP benefits, particularly for extremely vulnerable populations.

51. An Ottawa pilot project to assist people with serious mental health concerns, cognitive impairments and complex social needs found that many clients were restricted in their access to ODSP due to the inability to obtain a doctor. Other barriers identified were the lack of a health card and the difficulty obtaining the necessary medical documentation for the application.

Anglican Social Services Centre 454 (2007), "ODSP Application Support Worker Pilot Project – Outcomes and Recommendations", Exhibit M to the Affidavit of Mary Marrone at p. 270.

52. The project's final report noted as follows:

> The struggle to find a doctor is being experienced by many people in Ottawa, across the province and throughout the country. Those who are trying to find a doctor will tell you that doctors accepting new patients are looking for relatively healthy, easy to serve patients who have little demands. Contrast this "ideal" patient to an individual who is homeless or street-involved, who is living in poverty, who has significant health problems and who requires documentation to support a disability application. The [Application Support Worker ("ASW")] has experienced a number of occasions where she had referred clients to doctors who were purportedly taking new patients but the doctors declined to accept the clients. Needless to say, the biggest challenge the ASW has experienced has been to find clients the medical support they require.
>
> By the end of April 2007, the ASW was working with 41 people who did not have a doctor. Although they may have access to walk-in clinics or emergency departments, there is no one medical professional who knows the client well enough to be willing to complete the medical form of the ODSP application package. <u>The lack of their own doctor is obstructing clients from securing better financial assistance benefits to which they are very likely eligible</u> [emphasis added].

Anglican Social Services Centre 454 (2007), "ODSP Application Support Worker Pilot Project – Outcomes and Recommendations" Exhibit M to the Affidavit of Mary Marrone at p. 276.

53. Some groups that experience these barriers most significantly include First Nations communities, people with serious mental health concerns, cognitive impairments and complex social needs and homeless people.

54. Even for those with a regular family doctor, completing the ODSP forms is a time consuming and often confusing endeavour. The ODSP Action Coalition, an organization of ODSP recipients and advocates, has called upon the ODSP program to provide greater clarity to the medical community:

> To prove their disability, clients are expected to provide medical verification for each specific impairment and restriction they experience. Usually, verification must be accomplished through a specialist's report, but constraints imposed by the health care system mean that people often do not have timely or proximate access to specialists. …
>
> This often results in people being denied eligibility due to incomplete medical information. The situation is complicated by the fact that medical professionals are paid little to complete forms and receive little or no training to understand the complex requirements of ODSP. People are denied benefits because medical professionals do not understand and/or provide the level of information required by the [Disability Adjudication Unit], because medical specialists are not available to confirm people's conditions, and/or because the investigations required to satisfy ODSP requirements are not seen by medical specialists as medically necessary.
>
> …
>
> **Recommendation 4:**
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> …
>
> • ODSP should provide medical practitioners with better information about the program's verification requirements in order to ensure timely and accurate medical reporting, such that applicants are not put into economic and social jeopardy due to insufficient, inaccurate, or untimely administrative processes.

ODSP Action Coalition (June 27, 2011), "Dignity, Adequacy, Inclusion: Rethinking the Ontario Disability Support Program", Exhibit O to the affidavit of Mary Marrone, p. 290.

55. In light of the clear evidence of inequitable access to a regular primary care physician, it is important that the standard of practice reflect the context in which a patient is seeing a physician and the degree of information required for a particular form. Patients who rely upon

walk-in clinics – who are more likely to be low-income social assistance recipients – should not be denied access to important health benefits.

56. As an organization committed to the health of Ontarians, the College of Physicians and Surgeons must have an interest in ensuring access to social benefits for those who qualify. Indeed, as the College's Practice Guide confirms, the College has an "ethical and statutory responsibility to serve the public by regulating physicians in the public interest." Physicians have a corresponding responsibility to "advocate on behalf of their patients to advance policies that promote the health and well-being of the public."

Exhibit 24: CPSO, "Practice Guide: Medical Professionalism and College Policies", at pp. 8, 12.

57. Thus, in assessing the various opinions before this Honourable Panel on the requisite standard of practice for completing Special Diet Allowance application forms, ISAC asks that the above principles guide the analysis. ISAC asks that this Honourable Panel consider the potential province-wide impact of its decision, as well as the other social benefit programs that may be affected. Most importantly, it is submitted that the standard of practice must identify a minimum standard that is reasonable for the context in which these forms are completed. The standard of practice should not be a "gold standard" based on an erroneous assumption that every Ontarian has access to a regular family doctor and should assure reasonable access for those who qualify.

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Jackie Esmonde (LSUC 47793P)

Income Security Advocacy Centre
425 Adelaide Street West, 5th Floor
Toronto, Ontario
M5V 3C1

Tel: 416-597-5820 (X 5153)
Fax: 416-597-5821

Lawyer for ISAC