THE SPECIALISTS' DIVORCE

Dr. David Jacobs wants to help about 3,000 specialists separate from the Ontario Medical Association, but will they? More importantly, should they? **BY TRISTAN BRONCA**

Dr. David Jacobs is happy with the deal.

It had been about five years since doctors in Ontario had a contract, which is to say, five years since they had any guarantees they wouldn't wake up to a fresh set of funding cuts. In February 2019, three arbitrators reached what the Ontario Medical Association (OMA) and the Ontario ministry of health—two groups that agreed on virtually nothing during negotiations—both called a "sensible compromise." Dr. Jacobs didn't expect premier Doug Ford to be able to undo years of cuts made under the Liberals. He didn't even seem to mind that he didn't really try.* But this arbitration ruling—this deal—was good for all doctors.

* Doug Ford's government did return to closed-door negotiations with the OMA, but that quickly fell apart, and when they entered arbitration, the government adopted the exact same arbitration position as their Liberal predecessors.

Which is why he wants to take a break, at least until contract negotiations start up again next year. Call it a temporary truce from his war on the OMA.

THE CASE FOR THE OSA

Dr. Jacobs is possibly the most polarizing doctor in the country not named Barrette or Hoskins. As a radiologist, he is a founding member of the Ontario Specialists Association (OSA), which formed after his very public resignation from the OMA board last fall. In the ensuing weeks, he and other leaders at the OSA organized a referendum in which thousands of doctors voted on whether to leave the OMA.

In eight of the OMA's specialty sections, the majority voted to leave.

When you ask doctors why they wanted to get out of the OMA, they'll tell you that it's not just about money. Which is mostly true. The matters that led to the formation of the OSA are more complicated.

The OMA is made up primarily of generalists. About 40% of its 31,500 practising members are family doctors, which means their concerns tend to occupy a proportionate amount of the OMA's efforts and resources. As a result, members of smaller specialties say their concerns often don't get due consideration. And when those specialists gross hundreds of thousands of dollars more than other specialists, their concerns may get buried without anyone feeling especially bad about it.

One of those specialties is gastroenterology. Twenty-three years ago, Dr. Michael Gould founded the Ontario Association of Gastroenterology, which became a leading member of an earlier coalition of specialists in the 1990s. Their goal, he said, was not to break away from the OMA but to get de-Randed so its members would not be forced to pay OMA dues. They failed. Still, as he told the *Medical Post*, this sense of dissatisfaction with the OMA dates back more than 30 years.

Take outpatient endoscopy clinics, for example. Gastroenterologists fund these clinics out-of-pocket and

Dr. David Jacobs photographed by Brooke Schaal

Dr. Gould contends that these expenses can account for more than 40% of their earnings. For the last decade, gastroenterologists have been applying for a technical fee that would at least recognize this, but the OMA has taken no action to support it. At one point, the gastroenterologists even hired a consultant to make their case, which Dr. Gould said the OMA has so far ignored.

Nephrologists, cardiologists and many others have experienced similar problems. Whether it's an attempt to introduce new fee codes to fund new procedures that have become the standard of care, or trying to get alleged accounting errors related to their pay corrected, these specialists say their issues are often drowned out by others.

They don't necessarily blame OMA members or even the leaders. Dr. Jacobs suggested it's in the organization's DNA. As Dr. Gould said: "There's no way we're going to be represented properly in an organization in which half of all members are family doctors. And because of where we appear on the income scale, we are always on the side that gets something removed from it or gets painted as 'greedy' despite our efforts to explain why where we are in the pecking order may not be accurate."

Some have argued that the OSA will simply become a microcosm of the OMA; that even with 3,000 or so members, the same squabbling will arise. But none of the specialists who spoke with the *Medical Post* agreed. Dr. Jacobs argued that within a smaller association, each specialty would have a representative that dealt directly with government. You want to discuss a cardiology code, you'd discuss it with a cardiologist, whereas at the OMA, such requests are filtered through a bureaucracy that begins and ends with the board. The OSA would also have a non-mandatory dues model. Unhappy specialties could simply vote to leave.

There are other concerns with the OSA. The most obvious is that the optics that have hampered these specialists at the OMA would be far worse playing out in the public eye. You thought it was tough trying to convince your colleagues to put more money in your pocket* when some in your specialty are billing upwards of $1 million a year, try convincing a slash-happy premier who's been voted in to balance the budget. You think *that person* is going to be easier to negotiate with?

* Even money to which you're entitled on account of previous accounting errors, new responsibilities, expenses, etc.

Well, according to the specialists, yes. Framing this issue around specialists' earnings mischaracterizes the value for these services, they argued. More importantly, it fails to consider the pressure the government is under to ensure nothing happens to those services. When Ontario floated the idea of changing the types of anesthesia it funded for colonoscopies, the public was livid. Gastroenterologists didn't even need to raise the issue. Matter of fact, when we think about wait times or any of the other high-profile problems in Canadian healthcare, many of the pinch points are specialists' services.

That is not to discount the work of family doctors, several specialists told the *Medical Post*. Primary care is essential for a well-functioning healthcare system. It's just that as far as political crises are concerned, primary care doesn't have the same visibility. When people can't get a family doctor, they go to walk-ins or ERs. It's not—as one specialist put it—"as in your face."

Moreover, Dr. Jacobs said he believes that the formation of the OSA would actually be good for the OMA. The OSA would likely align with the OMA on most matters of health or public interest, and offer its support when appropriate. An OMA fully focused on representing generalists would become "more nimble," better able to respond to the needs of membership that is not fighting with itself. The differences within the medical profession are as profound as those between a plumber, an electrician and a carpenter. You don't need them all under one roof because you respect the diversity of their opinions. At some point, unity for unity's sake may not be worth it.

MEETING DR. JACOBS

Dr. Jacobs didn't always plan on becoming a radiologist. Originally it was brain surgery he wanted to get into.

After growing up in Montreal, he attended Oberlin College in Ohio, where he earned an undergraduate honours degree in neuroscience and neuroelectrophysiology. He spent his summer between years two and three of medical school at the Montreal Neurological Institute, observing and assisting in the OR. He said that it was an exciting time but joked that "every single neurological resident whispered 'it's not too late—get out while you can.'" He decided instead to pursue urology at Queen's, but after his first six months in core surgical training he began to have trouble walking. He was diagnosed with a rare but benign tumour in his hip that required surgery and radiation. After a recurrence, which required more surgery and radiation, he dropped out of urology. He couldn't stand for long periods of time, which would have made a career in a surgical profession like urology impossible.

After a very brief stint in ophthalmology, he transitioned to radiology, which still had a few surgical components. "I was always impressed by the miracles they were able to perform through pinholes," he said. But the learning process was very different. The breadth of readings spanned most areas of medicine and he struggled.

He met his wife at Mount Sinai hospital in Toronto where she was, at the time, working as a technologist. They now have two kids; a daughter, Maia, who's 15 and a son, Alex, who's 13. Alex already has ambitions of medicine. In fact Dr. Jacobs said Alex has been an observer in many of the strategy sessions and political conversations related to official OSA business. "He has been sitting in the passenger seat of the car on 90% of these calls," Dr. Jacobs said. "I don't think there are more than maybe a handful of people who have a deeper understanding of medical politics than him. He's tickled by all of it. He sees it as a normal function of being a physician."

Few would describe Dr. Jacobs' political activities as "normal." His profile

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began to rise in 2016, when he became one of the leading figures in the Coalition of Ontario Doctors, a group at the crest of a wave of opposition against the OMA. That coalition included a number of grassroots physician organizations, such as Concerned Ontario Doctors, as well as the backing of some very well-funded groups like the Ontario Association of Radiologists (a group in which Dr. Jacobs serves as vice president). They pressed for a general membership meeting to vote on the infamous tentative physician services agreement in 2016, not trusting the OMA's governing council to respect an advisory poll of members. They bombarded the OMA board with threats of legal action related to the meeting. As one previous OMA board member recalled, it got to a point where it became almost impossible to do anything besides deal with the letters and phone calls from lawyers.*

* Dr. Shawn Whatley, who was elected president of the OMA in 2017, pointed out that radiologists have been known to bring lawsuits against the association as far back as the 1990s. Though there was clearly an exceptionally high amount of legal activity around the 2016 tPSA, Dr. Whatley said it was wrong to suggest that Dr. Jacobs was a) single-handedly driving the activity; or b) doing anything new.

When the general meeting was held in August 2016, the contract was voted down by a clear majority. Within six months, the six-member OMA executive—including the president and the president-elect—had resigned.

Thus began what was supposed to be a new chapter for the OMA. Not only was a new executive formed, but there was significant turnover both at the board and at council. The OMA launched a series of governance changes, still in progress today, to better engage members. Then in June 2018, Ontario's Liberal government, the axeman for nearly a decade of cuts, was voted out, signalling a hopeful new start to government relations.

Dr. Jacobs was at the centre of it all. He became a member of the new OMA board and he, like many others, seemed confident things were going to change for the better.

Until he wasn't anymore.

'YOU'RE GOING TO HAVE A FIGHT'

Relativity—how to determine what one doctor's services should be worth relative to another—is a problem in every province and, for all the years it has haunted the profession, it's probably safe to say it will always be a problem. What our Canadian experience has shown is that as funding gets tighter, this problem has a way of getting uglier.

Dr. Jacobs described it like this: When you have 10 stray dogs in a room, and 10 bowls overflowing with food, you don't have a problem. It's when you have three bowls that you have a problem. If you add more food to one bowl while another dog is eating, you don't have a problem. If you take the food out of someone else's bowl, you're going to have a fight.

It is official OMA policy that the association must achieve pay equity by 2024 which means (to conclude this inadvisable analogy) food is going to have to come out of someone's bowl. There simply isn't enough new money flowing into the physician services budget to raise the compensation of doctors who are, according to the OMA's methodology, undervalued—certainly not enough to offset pay inequities with specialties such as radiology and ophthalmology within that timeframe.

In October 2018, at a special council meeting, the OMA's governing body voted to reallocate a maximum of 1% of funding from those higher-paid specialties and give it to undervalued specialties. The move was a shock for many on the board, including former past-president Dr. Shawn Whatley. He was the first OMA president elected after the resignations of 2017. He and other board members had made it a principle that the association would never, as he often puts it, "rob Peter to pay Paul." When council voted again at the November 2018 council meeting*, council backpedaled, deciding that the redistribution motion should not inform the approach to the then-ongoing negotiations, effectively staunching the special council motion.

* It just so happens that the OSA vote took place the same weekend as this council meeting.

Still, after that special council meeting, Dr. Jacobs knew he was done with the OMA.

The OMA leaders have tried to brush off the result of the OSA referendum, dismissing the "poll" as illegitimate*, but the fact that eight specialties voted to leave remains significant. Although it only amounts to roughly 5% of all OMA members, no group this large has seriously threatened to break away in the

last 25 years. No other association in Ontario appears to be as capable of negotiating independently, or as serious about replacing OMA offerings (the OSA has already sold about 500 insurance policies through RBC, a move to replace one of the OMA's products). Dr. Jacobs & Co. currently present the most plausible chance of undoing the legislation that shackles these doctors to the OMA.

* The OMA raised concerns about the methodology of the referendum, and said members had raised concerns about "irregularities" related to who received ballots and when. However, it's worth noting that while the OMA was legally obligated to provide Dr. Jacobs with some member contact information to conduct the vote, Dr. Jacobs suggested the association did not provide any more than that.

This is what makes Dr. Jacobs controversial. Thousands of specialists feel any other group is better than the OMA, and who after years of cuts are aggrieved their own representative body considered taking more away from them. "It is a very bad toxic relationship and it needs to end," wrote Dr. Murray Matangi, a cardiologist, in a comment on our website. "The consequences are irrelevant; we just want control over our own destiny. If that destiny is worse, then so be it." That—things getting worse—is precisely what others are so concerned about.

PROMISES MADE, PROMISES BROKEN

Dr. Jacobs has a way of speaking that suggests he knows something you don't. Both colleagues who support him and those who don't have described him as "very charismatic"—an effect which seems to have at least as much to do with the information he withholds as what he says. He knows something, or someone. But what exactly he knows and who he heard it from, well, he can't tell you that, not even off the record.

Which brings us to his connections with Ontario's Ford government.

Dr. Jacobs has emerged as one of Doug Ford's most prominent supporters in the medical community. A June 2018 online analysis from the National, a public relations firm, placed Dr. Jacobs among the most influential conservative voices in the province. His Twitter following has surpassed 14,000 people, and since the Wynne days, his salty tweets directed at Liberal politicians often rack up hundreds of likes and retweets. They have also, on occasion, led to amusing or bitter exchanges with those on other side of the political aisle.*

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* The list of people with whom Dr. Jacobs has exchanged words online includes but is not limited to: the surprisingly progressive Ed the Sock of MuchMusic fame, and Gerald Butts, Trudeau's former Principal Secretary. His own personal code of what constitutes acceptable online conduct is not particularly complicated: be civil, but otherwise "mocking politicians is a victimless crime." With the exception of some of those political interactions, he does appear to avoid posting content that might offend, but his followers don't always. At the top of his feed is a pinned reminder to his "Twitter friends" not to post racist, violent or sexist tweets in response to his.

But in real life, Dr. Jacobs said he has only met Doug Ford twice, the first time at a fundraiser before Ford was elected. His first impression was a good one. He said the now-premier came across as "genuine" and "articulate"—two characteristics that he acknowledged don't always come across on TV.

Perhaps Dr. Jacobs' most likely tie to the administration is Dr. Rueben Devlin, who for 17 years was the president and CEO of Humber Hospital where Dr. Jacobs does most of his clinical work. Dr. Devlin is now the chair of the Premier's Council on Improving Healthcare and Ending Hallway Medicine. It is one of the most high-profile positions in the Ford administration, and in it Dr. Devlin is overseeing the massive transformation of healthcare in the province.

Whatever the nature of these connections to the administration, it appears that those in the power structure had offered Dr. Jacobs two key assurances. The first: that doctors would have an opportunity to choose who represents them in negotiations, an assurance that the *Medical Post* heard first-hand prior to the OSA vote. A top government official not authorized to speak publicly suggested the premier would seriously consider de-Randing Ontario's doctors and taking away sole negotiation rights from the OMA if the OSA vote indicated that was what doctors wanted (although the *Medical Post* has not been able to speak with the source or anyone in the premier's office since the vote). The second assurance: if doctors choose to be represented by the OSA, the process of breaking away would not affect doctors who remained with the OMA.

That second assurance, it now appears, wasn't worth very much.

On Monday Dec. 10, 2018, about a month after the OSA vote, Craig Rix, legal counsel to the ministry of health at the arbitration hearings, sent a letter to panel chair William Kaplan saying that the ministry of health "cannot agree to the continuation of the arbitration proceeding." Rix said there was "clearly a public dispute about whether the OMA is the exclusive representative of physicians in Ontario . . . the (ministry) lacks confidence that the OMA can deliver on the outcome of any arbitration decision." They dismissed their representative on the arbitration panel two days later.

Physicians had fought for years for arbitration, so when the government tried to walk away doctors were apoplectic. The OMA informed members of the government's decision and went to the media, and within 48 hours, 5,466 OMA members had written their representatives in the provincial legislature. Much of that fury was then turned on Dr. Jacobs when it was revealed that, at some previous date, he promised doctors on social media that this wouldn't happen.

"Binding arbitration will not be taken away from anyone," he wrote. "Full stop. I stand by this statement. Copy it. Screen capture it." That screen capture soon began making the rounds online. He said his practice was threatened. A former president of the College of Physicians and Surgeons of Ontario compared him to Judas.

"I suspect he was manipulated by the conservatives," said internist and palliative care physician Dr. Hershl Berman. While Dr. Berman, a member of the NDP party, has had his fair share of online spats with Dr. Jacobs, he said he doesn't believe Dr. Jacobs would have thrown his colleagues under the bus intentionally. "He probably really believed they would continue to arbitrate. . . . I think that he was led to believe, intentionally or unintentionally, that he had some sort of influence with the government. They basically abandoned him."

The government did return to arbitration in the face of outcry, a decision on which ministry of health spokespeople have declined to comment. Dr. Jacobs described that period as a "very, very unpleasant time" but when asked whether the episode rattled his faith in the Ford government, he said no. "Whatever tactics they used, it resulted in a fair deal for all sides. The ends justified the means."

QUEBEC'S REPUTATION PROBLEM

When asked what an OMA/OSA model would look like, OSA representatives frequently point to either B.C. or Quebec. In B.C., specialty sections are technically separate organizations from the medical association, Doctors of BC. But Doctors of BC still negotiates on behalf of all doctors. In Quebec, that's not the case.

The Fédération des médecins spécialistes du Québec (FMSQ) has existed for as long as government has negotiated directly with doctors, as has the Fédération des médecins omnipraticiens du Québec (FMOQ). There is still a medical association in Quebec (the QMA) which fulfills many of the other functions of medical associations, such as advocating around physician professionalism and societal health issues. But when it comes to dollars and cents, that's the domain of the FMSQ/FMOQ.*

* The FMSQ is different than the OSA in that the FMSQ represents all specialists, including the lower-earning ones. While the OSA did extend an invite for all OMA specialty section heads to consider giving their members a vote on joining the OSA, the only sections whose leaders expressed interest in a vote were those that the OMA considers "overvalued" and thus may have stood to lose something by staying with the OMA.

"Quebec's is the only model in Canada whose medical bodies are more unions than associations," said Dr. Hugo Viens, an orthopedic surgeon who is also the president of the QMA. Dr. Viens told the *Medical Post* that the two lobbies are hugely powerful, even compared with other medical associations across the country. That is, in part, because their focus is singular: to protect doctors' income. Stewardship of healthcare resources and other similarly high-minded goals simply aren't part of their mission the way they are in places like Alberta, he argued.

But for this reason, he said the public reputation of Quebec doctors has taken a beating over the last several years. Since 2014, he said the FMSQ has exerted massive influence on the government to get pay raises to put them on par with Ontario. After a protracted dispute with health minister Dr. Gaétan Barrette, who is himself a radiologist and former head of the FMSQ, the fédération even succeeded in pressuring the government to have him removed from negotiations.

All of this has made them very successful in their mandate and Dr. Viens said he understands why Ontario might want to emulate this model. But it comes at tremendous cost. "We're seen as mercenaries," he said. "You don't want to reproduce Quebec's model; it's not good for the system, it's not good for the profession."

THE OMA CHANGES ITS TUNE

Dr. Berman said he believes the OSA is "dead in the water," and he is not alone in thinking so. The *Medical Post* reached out to Ontario's ministry of health and Health Minister Christine Elliott's office to ask if there had been any meetings related to the possible formation of the OSA, and when the government was expected to make a decision. They shared none of those details, and their official answer remained the same as it always has: "The Ministry of Health and Long-Term Care recognizes the OMA as the exclusive representative of physicians practising in Ontario."

The *Medical Post* wrote back: "I'm going to take that to mean the government has made a decision on the OSA and does not plan to amend legislation. Can you confirm that's accurate?"

Spokesperson David Jensen responded: "Yes, the government does not plan to amend legislation."

Dr. Jacobs has heard this before. He explained that the OSA has been dealing with the premier's office and with the other changes happening in Ontario's health system, he understands

that the existence (or not) of the OSA isn't exactly a priority for the ministry of health.* While Dr. Jacobs said the OSA is continuing its activities in the background, its public-facing efforts are on pause. After all, doctors are happy with their arbitrated agreement.

* As of this writing, the *Medical Post* has been unable to obtain comment from the premier's office.

But as more time passes, one question will continue to pop up: How much are Dr. Jacobs' assurances worth now?

What has undeniably changed during all this is the OMA. Just recently Dr. Samantha Hill, a cardiac surgeon, was elected the next president, despite the fact that doctors had chosen pediatrician Dr. Hirotaka Yamashiro in a membership-wide vote. The voting in both the member poll and at council clearly followed relativity lines, with specialists supporting Dr. Hill, and generalists, Dr. Yamashiro. That council would overturn a clear directive from its members appeared not only to undermine the OMA's efforts to engage members by giving them a vote in the first place, it also appeared to be an attempt to placate dissatisfied specialists.*

* It may have worked. Dr. Mark Benaroia is a nephrologist in Kitchener who voted to leave the OMA for the OSA. The *Medical Post* asked him if, tomorrow, the government made the necessary changes to allow the OSA to form, would he join? He said he wasn't sure he would leave the OMA. "If you were writing this article three months ago I would have had a different answer."

The flipside of that, of course, is that OMA leaders have now alienated many others.* Dr. Tom Hastings, the section chair of psychiatry at the OMA, said he believes the association is effectively being "held hostage" by specialists threatening to separate. "Eventually you have to call their bluff." He argued that one of the reasons dissatisfaction levels are so high is because the OMA has allowed the problem of relativity to spiral out of control, and is now constantly caught on its back foot, trying to appease members with reactive decision-making rather than a long-term strategy. That strategy, he said, would require some very hard decisions.

* On the coverage of the OMA presidential vote on our website, one neurologist (jokingly?) said it was time for the lower-paid specialties to secede from the OMA.

Dr. Hastings pointed out that the so-called overvalued specialties make up about 30% of the OMA. Again, the ones who voted to leave make up only about 5%. "I think not addressing relativity is a far greater risk to our profession than the loss of those members, and we're not going to address it if we're scared to lose those members."

But let's say, hypothetically, that the specialists are allowed to separate, that they do get what they want, and if—again hypothetically—they are battered by an indifferent and savings-hungry government, then of course Dr. Hastings and others would welcome them back to the OMA. "I don't want to see my colleagues get hurt," he said, pointing out that previous government cuts have been far steeper than the 1% maximum that the OMA had proposed at its special council meeting. "But I also don't believe that if the higher billers left it would weaken the association the way (OMA leaders) are suggesting. I think doctors are better as a unified group, but the threat of separation shouldn't stop us from doing what's right."

On this, Dr. Jacobs and Dr. Hastings may have reached a rare point of agreement: Perspective often requires distance. **MP**