The Royal College of Physicians and Surgeons of Canada
Le Collège royal des médecins et chirurgiens du Canada

Safeguarding the Quality of the Educational Continuum and Medical Workforce in Canada's Complex Health Care System

July 2008

> The Royal College unequivocally reiterates that all systems providing medical education and training must provide the highest standards of teaching, research and quality of care. Additionally, the College calls on all stakeholders to ensure that patients receive timely access to medically necessary publicly funded care, irrespective of the mechanisms in place to deliver care. Finally, governments must continue to support policies that provide adequate resources, compensation and a satisfactory balance between personal and professional lives for all health care professionals.

Preamble

The education and training of Canada's future physicians and the ways in which health care is being delivered are becoming increasingly complex. Greater regionalization, new distributive models of medical education and the increasing presence of private clinics have meant that health care delivery and medical education and training are often occurring in what may be considered to be non-traditional sites.[1] This growing complexity may put at risk the ability to provide an appropriate case-mix for residents, quality assurance, support for basic and clinical research, and ensured access to the highest standards of care through an equitable distribution of physician human resources (HR).

Context & Issues

Various factors have recently brought the role of private clinics in Canada's health care system to greater prominence. The pressure to reduce waiting times has led several provinces to devolve the provision of specific publicly-insured services to private centres.[2] Privatized health care has also taken new forms including private Internet-based consultations. Also, developments such as the 2005 "Chaoulli decision" have prompted predictions that private funding and delivery of health care will play a greater role in the near future.[3] These have given rise to several issues, including:

- *Ensuring an optimal educational experience*
  It has been observed in various jurisdictions that private centres tend to perform relatively straightforward, high-volume elective cases, leaving public hospitals to deal with an increasing number of complex and high-risk patients.[4] This leads to the concern that residents training solely in the traditional public centres are being deprived of the experiences that have been devolved to private clinics.

- *Sustaining scholarly activity*
  Greater use of private settings and publicly funded centres not previously associated with faculties of medicine may result in a loss of capacity for research and of opportunities for research experience available to residents.[5] As well, these new approaches may result in a loss of the full dimensions of scholarship, generally understood to include discovery, integration, application and teaching[i].

[i] Glassick, C. Referencing the 1990 work of Ernest Boyer in *Academic Medicine*. 75 (9): 877-880, September 2000

- *Assuring quality and safety of patient care*
  As patients move between public and private centres, continuity of care may suffer. The highest quality care, with organized followup and management of complications, is essential in every system.[6]

- *Ensuring an equitable distribution of physician human resources*
  Physicians in Canada, except in Ontario, have the option of working in either the public system (paid for by provincial/territorial health insurance plans) or in the private sector (charging patients directly for services). With the exception of Newfoundland and Labrador, legislation prohibits physicians from simultaneously being reimbursed by provincial/territorial health insurance plans and also charging patients directly for those services.[7] In this context, some have expressed the concern that physicians may be lured away to the privately-funded system, thus depriving the public system of sufficient physician human resources.[8] Although governments in most OECD countries have adopted different measures to ensure an appropriate allocation of physician human resources in both public and private systems,[9] the international evidence on the impact that parallel public-private systems have on access to care is decidedly mixed.[10]

- *Establishing a research agenda*
  It has been noted by various experts that there is a lack of rigorous research documenting the overall impact of privatization and dual practice on the health system.[11] Given this gap in knowledge, there is also little to no systematic assessment of the impact of privatization on physicians' ability to meet the ethical codes and standards of professionalism that guide the profession.[12]

Recommendations

The Royal College has long affirmed its support for Canada's public health care system and the principles enunciated in the Canada Health Act. Notwithstanding, the Royal College also recognizes that the involvement of the private sector in health care is a reality in Canada. It is within this context that the RCPSC recommends the following:

1. If governments or regional health authorities devolve care to privately operated medical facilities, formal relationships between these facilities and faculties of medicine must be established.
   - Formalized relationships are necessary to ensure that residents are exposed to an appropriate case-mix and have the opportunity to develop the full breadth of Roles a specialist must fulfill in their professional activities: Medical Expert, Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional.[ii] Private medical centres can be valuable training environments with their regular and high volume of procedures, without which it may be difficult for residents to experience the full breadth of their discipline. The ability of residency programs to meet Royal College accreditation requirements must be ensured.
   - Formalized relationships will also help improve continuity of care, patient followup and management of complications, and ensure the highest standards of care overall.

2. When faculties of medicine establish relationships with medical centres, these affiliated programs must
   - have an appropriate number of practitioners with faculty appointments;
   - fulfil requirements for educational rotations as required by the faculties of medicine and the Royal College's standards of accreditation; and
   - be encouraged and supported to fulfil their potential to conduct quality research, whether basic, clinical, translational, outcomes-related or other.

[ii] These Roles are enunciated in the RCPSC's CanMEDS Roles framework. The CanMEDS competencies have been integrated into the Royal College's accreditation standards, objectives of training, final in-training evaluations, exam blueprints, and the Maintenance of Certification program. For a complete description of the CanMEDS Competency Framework, go to http://www.rcpsc.medical.org/canmeds/CanMEDS2005/index.php.

These provisions are necessary to ensure there is a mechanism in place to train medical students and residents in a timely fashion while maintaining appropriate educational standards. These provisions will also ensure that residents are able to develop their Role as Scholars[iii] as detailed in the CanMEDS Roles framework, maintain the quality of the research enterprise, allow for the evaluation of patient outcomes and establish productive relationships between clinicians and researchers.

3. Similar to public centres, private medical centres must be expected to achieve the highest standards of care, and be evaluated using appropriate evaluation criteria. All education and training must be held to the same standards, wherever training occurs, and comply specifically with Standards A2 and A3 of the General Standards of Accreditation of the RCPSC.

4. Governments must ensure that patients have timely access to medically necessary, publicly funded care of the highest standards, irrespective of its delivery in the public or private systems.

5. Whether physicians are practicing in publicly or privately funded systems, the medical profession has a collective responsibility to advocate for timely access to the highest standards of care for all patients and to educate future physicians.

6. Governments must support policies that provide adequate resources to the educational and health care systems; assure appropriate compensation for the full sphere of physicians' activities, including teaching, research and administration; and sustain a satisfactory balance between physicians' personal and professional lives. Work environments must be conducive to the retention of physicians in Canada and ensure that their well-being and that of their patients is safeguarded.

7. There must be concerted action to fund and support research that evaluates the impact of privatized health care on access to care, education, standards of professionalism as generally understood and defined under the Royal College's CanMEDS Professional Role[iv] and the deployment of physician human resources in Canada.

[iii] Under the RCPSC's CanMEDS Scholar Role, physicians are able, among other competencies, to contribute to the creation, dissemination, application, and translation of new medical knowledge and practices.

[iv] The complete description of the CanMEDS Professional Role is included under end note 13 and a complete description of the CanMEDS Competency Framework, which encompasses seven Roles, is available at http://www.rcpsc.medical.org/canmeds/CanMEDS2005/index.php.

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End notes

[1] Education and training is also being taken out of traditional sites, with the recent emergence of distributed medical education (DME). The goal of DME is to enrich undergraduate and postgraduate medical education by increasing exposure and learning in distributed urban and rural community and hospital settings.

[2] Public policy decisions, such as those related to reducing wait times, are resulting in patient care being devolved to specialized or single-purpose centres, both within the public and private sectors. For instance, there are documented instances of governments having certain publicly insured services being provided by private clinics in various provinces, including Alberta, Manitoba, Ontario and Quebec.

[3] In June 2005, the Supreme Court ruled as unconstitutional the prohibitions of Quebec's health insurance legislation against private insurance contracts for insured services and private payment for hospital services. While the "Chaoulli decision" was seen by some as a landmark that would allow for the introduction of private health care in Canada, this has indeed been the case for years.

- Ontario has had a total of 24 private hospitals functioning in the province during the second half of the 20th century. At present there are eight private hospitals in Ontario licensed under the Private Hospitals Act. Two of these private facilities are surgical hospitals, the Don Mills Surgical Unit and the Shouldice Hernia Centre.
- Among the 304 health institutions registered in 2005 and 2006 in the province of Quebec, 110 were private, according to the Quebec Ministry of Health's 2005–2006 annual report.
- A range of non-insured services and drugs have always been covered by private insurance or by patients directly. Over the last decade, the ratio of public to private health expenditures in Canada has remained at around 70:30.

[4] In the United Kingdom, the Royal College of Surgeons, the Royal College of Physicians and the British Orthopaedic Association, to name a few, expressed the concern that Independent Sector Treatment Centres (ISTCs) tend to "cherry pick" the more straightforward cases, thereby leaving public hospitals to deal with an increasing number of complex, high-risk and high-cost patients. Additionally, it was felt that these private centres are unable or unwilling to deal with the management of complications. However, it may also be argued that from a quality and cost perspective, such an allocation of case loads allows for the most appropriate site to perform a particular medical service.

[5] In the United States, it has been observed that clinical researchers in settings with high levels of managed care publish fewer scientific articles and receive lower levels of NIH funding.

[6] The "plurality of provision," which includes both public and private providers, is seen as having a positive effect on the public health sector by prompting innovation and efficiencies. Also, the independent (i.e. private) health sector in England is required by its contractual requirements to provide data on outcomes that is much more detailed than that required of National Health Services trusts or individual consultants, thereby providing some measure of quality in independent centres. However, in 2006 the British Orthopaedic Association (BOA) identified concerns about patient followup and management of complications as patients are shifted between the public and privately operated centres known as ISTCs (Independent Sector Treatment Centres). It is suggested that the requirement of ISTCs to provide outcomes data may result in the development of better data in the country as a whole, which ultimately will be to the benefit of patients.

[7] Although physicians can opt-out of the public health care system in most of Canada, provincial governments have implemented a number of policy tools to ensure that the option to opt-out does not lead to an exodus of human resources from the public to the private sector. The fact that the vast majority of physicians in Canada do not opt-out of their provincial medicare plans suggests that this system of incentives and disincentives is proving effective in keeping the workforce within public health care. As of March 31, 2007, no physicians had opted out of provincial health insurance in P.E.I., Nova Scotia, Newfoundland and Labrador, New Brunswick, Alberta, Manitoba, Saskatchewan, the Northwest Territories, Nunavut or the Yukon. As of 2007, one physician was a non-participant in provincial insurance plans in British Columbia. Ontario suspended the option to opt out of its provincial insurance plan in 2004. The *Canada Health Act Annual Report 2006–2007* does not provide the number of opted-out physicians in Quebec.

It is important to note that physicians may indeed provide *insured* services in the public system and *non-insured* services within the private system. Such practice patterns are, for instance, typical among plastic surgeons who frequently work in

the private sector providing non-insured cosmetic procedures while also providing publicly insured services in the public system.

[8] While the empirical evidence on this subject is mixed and a variety of regulations and policy tools implemented by the provinces have made such an exodus unlikely, the perception continues to exist among a significant proportion of Canadians—62 per cent of respondents to the *2006 Health Care in Canada* survey felt that the introduction of privately funded and delivered health care for services already covered by medicare would lead to a shortage of doctors in the public system.[8] However, 64 per cent of the same respondents also opined that private insurance would lead to shorter waiting times.

[9] Unlike Canada, a majority of jurisdictions also allow physicians to work in both the public and private systems, albeit to varying degrees. An analysis of the experience in these countries provides crucial insights into the management of physician resources in the face of a public and private health care system. Listed below is how some OECD countries have approached the issue of physicians working in the public and private sectors:

- Some form of separation exists between the public and private systems with restrictions placed on doctors practising in both systems in Canada, Sweden, Luxembourg, Greece and Italy.
- In Ireland, the consultants' collective contract contains provisions requiring a commitment to practice in the public system.
- In the UK, full-time National Health Services consultants are allowed to earn a maximum of 10 per cent of their income from private practice. A similar restriction is enforced in France.
- In the Netherlands, the fee structure for physicians is regulated to ensure that it is the same in the public and private sectors.

[10] With respect to the impact of privatization on timely access to care, a study of waiting times for surgery in Manitoba found that doctors who were doing both public and private cataracts had longer public waits than those who were doing purely public work. Similar results were also obtained in a study of cataract surgeries conducted in Alberta. Within the international context, Duckett argues that Australian data suggests that a growing proportion of surgeries in the private sector is correlated with longer public sector waiting times. On the other hand, some experts have argued that the reduction of waiting times in the UK can be partly attributed to the introduction of private centres competing for and providing the same services as the National Health Services. The OECD has noted that private insurance has enhanced access to timely care in some of its countries.

[11] For instance, García-Prado and González (2007) note that "there is a severe lack of rigorous empirical studies that quantify social costs and benefits of dual practice. Thus, the impact of allowing dual practice on social welfare remains an empirical question that needs to be addressed." Policy and regulatory responses, 2007, 142-152.

[12] The *Collège des médecins du Québec* (College of Physicians of Quebec), to name but one organization, recognizes the need to assess the impact of privatized medical services on physicians' legal and ethical obligations, which are integral components of professionalism.

13. The following description is an excerpt of *The CanMEDS 2005 Physician Competency Framework. Better standards, Better physicians, Better care*:

Definition: As *Professionals,* physicians are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour.

Description: Physicians have a unique societal role as professionals who are dedicated to the health and caring of others. Their work requires the mastery of a complex body of knowledge and skills, as well as the art of medicine. As such, the Professional Role is guided by codes of ethics and a commitment to clinical competence, the embracing of appropriate attitudes and behaviours, integrity, altruism, personal well-being, and to the promotion of the public good within their domain. These commitments form the basis of a social contract between a physician and society. Society, in return, grants physicians the privilege of profession-led regulation with the understanding that they are accountable to those served.

Elements:
• altruism
• integrity and honesty
• compassion and caring
• morality and codes of behaviour
• responsibility to society
• responsibility to the profession, including obligations of peer review
• responsibility to self, including personal care in order to serve others
• commitment to excellence in clinical practice and mastery of the discipline
• commitment to the promotion of the public good in health care
• accountability to professional regulatory authorities
• commitment to professional standards
• bioethical principles and theories
• medico-legal frameworks governing practice
• self-awareness
• sustainable practice and physician health
• self-assessment
• disclosure of error or adverse events

Key Competencies: *Physicians are able to…*

- demonstrate a commitment to their patients, profession, and society through ethical practice;
- demonstrate a commitment to their patients, profession, and society through participation in profession-led regulation; and
- demonstrate a commitment to physician health and sustainable practice.

Enabling Competencies: *Physicians are able to...*

1. Demonstrate a commitment to their patients, profession and society through ethical practice
1.1. Exhibit appropriate professional behaviours in practice, including honesty, integrity, commitment, compassion, respect and altruism
1.2. Demonstrate a commitment to delivering the highest quality care and maintenance of competence
1.3. Recognize and appropriately respond to ethical issues encountered in practice
1.4. Appropriately manage conflicts of interest
1.5. Recognize the principles and limits of patient confidentiality as defined by professional practice standards and the law
1.6. Maintain appropriate relations with patients

2. Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation
2.1. Appreciate the professional, legal and ethical codes of practice
2.2. Fulfil the regulatory and legal obligations required of current practice
2.3. Demonstrate accountability to professional regulatory bodies
2.4. Recognize and respond to others' unprofessional behaviours in practice
2.5. Participate in peer review

3. Demonstrate a commitment to physician health and sustainable practice
3.1. Balance personal and professional priorities to ensure personal health and a sustainable practice
3.2. Strive to heighten personal and professional awareness and insight
3.3. Recognize other professionals in need and respond appropriately

Approved by Royal College Council, July 7, 2008.