

Physician disempowerment: The View from Canada

Speaking notes for AIMS President Brian Lee Crowley

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Thanks to Peter Pitts and Mario Coluccio and the great team at Center for Medicine in the Public Interest for the invitation to be here. It is always a pleasure to find myself on a CMPI platform and to be able to say how much I admire and respect their work. I am also glad to be able to say that in addition to my role as head of AIMS I am now a Senior Fellow at the Galen Institute, another fine health care policy institute based right here in DC under the direction of Grace-Marie Turner.

I have been asked today to spend a few moments talking to you about the issue of physician disempowerment in Canada. The more I thought about this, the more it seemed to me that only the poetic mind and sensibility could encompass the illogicality, incoherence and absurdity of the destruction that has been wrought on the role of the physician in Canada in his role as front line provider, patient advocate and person charged with the ethical duty to ensure that their patients receive the care that they need. This destruction, while have many sources, derives chiefly from the decision in the 1960s that the relationship driving the health care system should cease to be that between patient and doctor and become that between politicians, organised provider groups and voters.

I sought inspiration then in poetry in summarizing the current state of the physician within the healthcare system in Canada and I was drawn inexorably to a poem I am sure that you all recognise by Elizabeth Barrett Browning, which I shall remind you of briefly. It goes as follows:

How do I love thee? Let me count the ways.
I love thee to the depth and breadth and height
My soul can reach, when feeling out of sight
For the ends of Being and ideal Grace.
I love thee to the level of everyday's
Most quiet need, by sun and candle-light.
I love thee freely, as men strive for Right;
I love thee purely, as they turn from Praise.
I love thee with a passion put to use
In my old griefs, and with my childhood's faith.
I love thee with a love I seemed to lose

With my lost saints, --- I love thee with the breath,
Smiles, tears, of all my life! --- and, if God choose,
I shall but love thee better after death.

With apologies to Browning, I have somewhat modified her poem and entitled it Ode to a Canadian Physician. It runs as follows:

How do I disempower thee? Let me count the ways.
I disempower thee to the depth and breadth and height
My bureaucratic soul can reach, when some aspect of the health system escapes my
control
For the ends of cutting my costs and using thy ideal Grace to shield me from the sting of
patient discontent.
I disempower thee to the level of everyman's
Most urgent healthcare need, by sun and candle-light, which are the pinnacle of the
technological sophistication thou art allowed.
I disempower thee freely, as men strive for “free” healthcare and end by merely
restricting access to thee;
I disempower thee purely, as they turn from specialists and hospitals in despair of finding
timely treatment there.
I disempower thee with a passion put to use
In my efforts to ingratiate myself with the electorate; Thank God for their childish faith.
I disempower thee with a loss of access to medical schools, thus ensuring that many will
never know the joys of thy tender care
I disempower thee with the breath,
Smiles, tears, and above all the income of all your life! --- and, if the Minister of Health
so choose,
I shall but disempower thee better if thou hast the temerity to prescribe a drug I judge too
costly, no matter how efficacious.

If I were to describe the physician’s loss of power within the health care system less
whimsically but in all its devastating details, I would make the following seven points.

**One: Potential physicians are severely restricted in their ability to choose the
profession (i.e. medical school)**

Several years ago, in one of its paroxysms of misguided but well-intentioned reform,
governments in Canada took the ill-considered advice of Prof. Bob Evans of UBC to the
effect that doctors were a “cost centre” in the health care system, because wherever there
were doctors there was a lot of billing of medicare. They therefore decided to reduce the

supply of doctors, thereby, they thought, reducing health care costs. They wet about this through two chief mechanisms. On the one hand they reduced access to medical school, and on the other they made it increasingly difficult for new doctors to obtain a “billing number” (i.e. the right to submit bills to the provincial health care authorities for treating patients). The combined effect of these measures, far from saving money, was to increase considerably the bargaining power of the well-organised professionals who were left. This explains, at least in part, the near universal experience of governments in Canada that new funding into the system disappears within a few years, leaving little trace in terms of shorter queues or improved productivity.

Two: Physicians are increasingly restricted in whom they can see (doctor shortages)

The resulting doctor shortage is now so severe that Statistics Canada reports that fully 5 million Canadians do not have a family doctor, and doctors are now engaging in lotteries to cull their patient list¹, as well as interviewing prospective patients in part to ensure that the really sick ones don't get on their patient lists because the state fee for an office visit will never make it economical to see such patients. The coming wave of Boomer-driven retirements can only exacerbate what is already a critical situation.

Three: Physicians are increasingly restricted in what they can prescribe

While doctors still enjoy the theoretical right to prescribe whatever drugs they consider appropriate, the reality is that a major part of their patient list gets their drugs reimbursed by the state, and the state has a very restrictive list of drugs (“formulary”) it will reimburse, a list moreover determined by costs, not evidence of efficacy. Rather than trying to keep track of who is insured by the state, and who is not, doctors in practice

¹ Extract from Tom Blackwell, *National Post* Published: Wednesday, August 06, 2008

MD uses lottery to cull patient list

Not first such case as lack of doctors causes huge caseloads

In the latest jarring illustration of the country's doctor shortage, a family physician in Northern Ontario has used a lottery to determine which patients would be ejected from his overloaded practice.

Dr. Ken Runciman says he reluctantly eliminated about 100 patients in two separate draws to avoid having to provide assembly-line service or extend already onerous work hours, and admits the move has divided the community of Powassan.

Yet it was not the first time such methods have been employed to determine medical service. A new family practice in Newfoundland held a lottery last month to pick its caseload from among thousands of applicants. An Edmonton doctor selected names randomly earlier this year to pare 500 people from his heavy caseload. And in Ontario, regulators have heard reports of a number of other physicians also using draws to choose, or remove, patients.

limit their prescribing to the state formulary, with sometimes extremely grave consequences for their patients.

Four: Physicians are increasingly restricted in getting their patients access to the latest technology

Canada's public health care system is undersupplied (compared to many industrialized countries) with the latest diagnostic and other technologies² such as MRIs, CT scanners, etc., because these technologies are expensive and their use leads to more consumption of health care services, as people with quicker and higher quality pictures of their health condition then expect these diagnoses to be acted upon. Just as doctors were seen to be cost centres, so too diagnostic tools "cause" health care use.

And in case you think that this is a temporary condition, the last big national public inquiry we had into the health care system (the so-called Romanow Report) published a research paper on the use of medical technologies in which the author essentially made the argument that people who fear that technology will make the health care system unaffordable, as more and more conditions become treatable, are mistaken. The author pointed out that new health care technologies only increase the costs of the system if you use those technologies. The logical prescription: keep your health care system primitive and your costs will be kept under control.

Five: Physicians have totally lost the power to determine what they will charge

In Nova Scotia where I live, doctors get paid \$28 for an office consultation, out of which they have to pay all their overheads, support staff, rent, utilities, insurance and their income is simply the residual when all the rest is paid. The consequence is that physicians are forced by economic necessity to push through high volumes of patients or they cannot make a living. In the clinic I attend some physicians have therefore posted notices that they will only deal with one health complaint per visit. If you have more than one complaint you must book a separate appointment for each one. This of course worsens the shortage of physicians because they cannot allocate their time efficiently, and from a physician's point of view the most valuable patient is the one who is not sick, since they take no time to deal with. The least desirable patients are the sickest, because they require lots of time and attention. But the price mechanism is forbidden to operate as a method of dealing with this problem. The price is fixed by the government and doctors are forbidden by law from charging over that official rate, even if both patient and doctor agree. This is a perfect illustration of the truth of the dictum of a good friend of mine to

² <http://www.fraserinstitute.org/newsandevents/news/6123.aspx>

the effect that “prices in the absence of genuine competition are merely government propaganda” and are useless in the allocation of scarce resources.

Six: Physicians are gaining some slight ability to practice in both the public and the private sectors after having lost that right for years.

The ability of physicians to deal with these problems by taking private patients was severely curtailed on the introduction of state health care by the simple expedient of saying to doctors that they were not compelled to take public patients, but that they had to make a 100% choice: you were either fully in the public sector or fully in the private sector. Since most doctors cannot live from private patients alone, the consequence was that the private sector for most physician services disappeared.

However, in recent years the problems of the system have become so severe that governments are now allowing (“tolerating” might be the more accurate term) the emergence of a private sector in competition with public sector providers. Thus several years ago the National Post ran a major story on health care in Quebec, the main title of which was: “Quebec: A province of private clinics”.

The result is that while the law technically outlaws such private initiatives, increasingly governments are implicitly turning to them to reduce pressures on the state system. Consequently the one word summary of emerging health care policy in Canada is “hypocrisy”, giving a whole new meaning to the Hippocratic oath.

Seven: Physicians have great difficulty getting their patients treated in a timely manner

According to the Fraser Institute’s eighteenth annual waiting list survey³, Canada-wide waiting times for surgical and other therapeutic treatments decreased in 2008. Total waiting time between referral from a general practitioner and treatment, averaged across all 12 specialties and 10 provinces surveyed, fell – wait for it -- from 18.3 weeks in 2007 to 17.3 weeks in 2008. So the national average (and in many provinces the average is considerable worse) is that patients have to wait somewhere between 4 and 4 and a half months to get needed medical treatment.

Physicians who in earlier times would have been active participants and managers of their patients’ care in hospitals and other settings are now simply gatekeepers who essentially disappear from their patients’ treatment once they have handed them on to specialists and hospital administrators. CIHI and College of Family Physicians of Canada

³ <http://www.fraserinstitute.org/researchandpublications/publications/6240.aspx>

recognize a marked reduction in scope of practice among Canadian Family Physicians- fewer physicians make hospital visits, obstetrical deliveries or care of people in long term care facilities.

Conclusion

I will conclude as I began, with a bit of poetry. Physicians surrendered great power to order their own professional lives and to act in the interests of their patients when physicians and hospital care was essentially taken under full political direction in the 1960s in a wave of ideological enthusiasm and economic ignorance. Despite the misgivings of some in the medical community, doctors largely embraced a public sector health care monopoly model, a monopoly that has only extended its tentacles and its centralising control in the intervening decades. Things are beginning to shift within the medical community, however, and the last two presidents of the CMA have been advocates of the private sector, a sea change of huge proportions. Like the wedding guest in Samuel Taylor Coleridge's Rime of the Ancient Mariner, they have been traumatized by the brave new world of our health care system and are beginning to draw the policy conclusions that follow from that experience:

He went like one that hath been stunned,
And is of sense forlorn :
A sadder and a wiser man,
He rose the morrow morn.

Thank you.