APPENDIX 1 — PHYSICIAN UNIQUE VALUE PROPOSITION

(Backgrounder — Strategic Session 1)

Value in health care

The concept of “value” is being used with growing frequency in the health care field. Porter has proposed that value should be defined around the customer (patient) and that it should be measured in terms of the achieved outcomes and not by inputs or volume of services provided. The term “unique value proposition” is defined as the value that a consumer can expect to receive from the seller or provider, and which they cannot expect to receive from any other provider.

Value in the crowded health care field

Over the past few years there has been a proliferation of formally recognized health professions in Canada. In Ontario, for example, there are 27 regulatory colleges in the human health area that regulate 29 occupations. In addition, there are numerous other unregulated health occupations. A number of non-medical health occupations have some service offering in the area of primary care that has historically been provided by a general practitioner or family physician. Non-physician clinicians such as nurse anesthetists and endoscopists are also emerging in specialty care, particularly in the United States. Some of these professions aggressively promote their value; for example a common claim by nurse practitioners is that they can do 80% of what a family physician does.

Given the numerous competing value propositions in health care, it is not surprising that there exists an apparent erosion in the public’s perception of the value of the physician. A 2013 public opinion survey of Canadian adults reported the following findings:

- 34% of respondents agreed that physicians are the heart of the health care system;
- 23% of respondents agreed that physicians make a contribution to health care that no other provider is capable of; and
- 56% of respondents agreed that “nurses and pharmacists are as knowledgeable as my doctor”.

Additionally, challenges in meeting public expectations of access to care exist and may be contributing to the perception. A 2013 public opinion survey conducted across 11 leading industrialized countries found that at 41%, Canadians were least likely to see a doctor or nurse the same or next day the last time they needed one. At 29%, Canadians were most likely to report that they had waited two months or more to see a specialist.

In further qualitative research with the public, the concepts of knowledge and accountability emerged as best depicting the unique value that physicians bring to health care.
Value and the medical profession

The practice of medicine is defined around the patient through the patient-physician relationship, which is the core of the practice of medicine. The tenets of the patient-physician relationship are set out in the Canadian Medical Association (CMA) Code of Ethics, the first of which is: consider the well-being of the patient.\textsuperscript{vi}

The unique value proposition of the physician lies in the application of a comprehensive set of knowledge about health conditions that affect all body systems to:

- diagnose a patient, whatever the initial symptom(s) might be;
- design appropriate treatment plans; and
- be willing to be held to scrutiny for care provided through professionally led regulation and discipline that begins in medical school and encompasses the medical career lifecycle.

Knowledge

Canada’s medical graduates are trained to uniform high standards that rival the best found anywhere in the world. Entry into a Canadian medical school is subjected to a rigorous, highly competitive process through which fewer than one in five applicants are admitted each year.

Most medical schools require a minimum of three years of undergraduate university education, however, many applicants have advanced degrees at the master’s or doctoral level. In addition to high scholastic achievement in grade point average there is a rigorous interview process to assess applicants’ suitability to study medicine using tools such as the Multiple Mini Interview that assess non-cognitive qualities such as teamwork, empathy and communication skills.\textsuperscript{vii}

Canada’s 17 medical schools offer either a four-year (academic) or three-year (full calendar year) undergraduate medical degree program that must meet the North American accreditation standards of the Liaison Committee on Medical Education.

According to these standards the curriculum must include the following:

- biomedical content in anatomy, biochemistry, genetics, immunology, microbiology, pathology, pharmacology, physiology and public health sciences;
- behavioural and socio-economic subjects;
- coverage of all organ systems and including dimensions of preventative, acute, chronic, continuing, rehabilitative and end-of-life care; and
- clinical experiences in both outpatient and inpatient settings.

In addition to the scientific content, the curriculum must also address skills such as communication, collaboration and cultural sensitivity.\textsuperscript{viii}

Undergraduate medical education in Canada is an active process, not a passive one, and is mainly delivered via intense small group interaction with a trained preceptor focusing on solving real-life patient problems. This education is resource-intensive both in terms of the numbers and qualifications of the teachers. Successful completion of undergraduate medical education results in the conferment of a MD degree, which in itself is the first stage of medical training. Thereafter, virtually all medical graduates enter postgraduate training. This consists of either a two-year family medicine residency that is accredited by the College of Family Physicians of Canada (CFPC) or a four-year (or more) residency accredited by the Royal College of Physicians and Surgeons of Canada (Royal College), either of which may be followed by further
sub-specialty training. Prior to entering residency training, medical graduates must pass Part I of the Medical Council of Canada Qualifying Examination (MCCQE), a computer-based test that assesses knowledge, clinical skills and attitudes.\textsuperscript{xv}

Both the Royal College and the CFPC postgraduate training programs are based on the acquisition of the competencies that are necessary to function in each of seven roles effectively. These roles are collectively referred to as CanMEDS.

The central role is that of medical expert, whereby physicians apply their medical knowledge, clinical skills and professional attitudes to provide patient-centred care. The other six roles include:

- Communicator – having effective relationships and exchanges with patients and their families
- Collaborator – working effectively within a patient centered health care team
- Manager – participating in health care organizations and decision-making about resource allocation
- Health advocate – using expertise and influence to advance health and well-being of patients, communities and populations
- Scholar – commitment to lifelong learning and generating and disseminating new knowledge
- Professional – demonstrated commitment to patients through ethical practice, professionally led regulation and high personal standards\textsuperscript{xvii}

Prior to becoming fully and independently licensed to practice medicine in Canada, medical graduates must pass Part II of the MCCQE which consists of a series of clinical stations involving a standardized patient. Successful completion of this examination confers upon a physician the designation of Licentiate of the Medical Council of Canada.\textsuperscript{xvii} At the end of residency training, applicants are eligible to sit for examinations of the CFPC or Royal College and the successful completion of these examinations is the normal requirement for successful licensure by a provincial or territorial medical regulatory authority.

Medical education requires of physicians a lifelong commitment to profoundly intensive learning, examination and continual medical education. It is the policy of the Federation of Medical Regulatory Authorities of Canada “that all licensed physicians in Canada must participate in a recognized revalidation process in which they demonstrate their commitment to continued competent performance in a framework that is fair, relevant, inclusive, transferable and formative.”\textsuperscript{xvii}

In order to maintain certification, the CFPC requires its certificants to complete a minimum of fifty hours of continuing professional development per year over a five-year cycle, and the Royal College requires four-hundred hours over a five-year cycle with at least forty hours per year.

**Application**

The practice of medicine is often described as both an art and a science. They come together through the exercise of clinical judgement, which Montogomery defines as “the practical reasoning or phronesis that enables physicians to fit their knowledge and experience to the circumstances of each patient”.\textsuperscript{xviii}

Through the application of clinical judgement the physician is the architect of a comprehensive treatment plan that includes prevention, treatment, supportive care, and assessment or monitoring of treatment results. The treatment plan starts with the differential diagnosis that is the cornerstone of the application of medical knowledge.

Establishing a differential diagnosis is a four-step process:
• taking the patient’s medical history and creating a symptom list;
• assembling a list of all possible causes of the symptoms, with consideration of what is most probable, keeping in mind the atypical and most serious possibilities;
• prioritizing the potential causes by placing the most serious ones at the top; and
• sequentially narrowing the list of possible causes by working through the list, using observations and tests.

Once a diagnosis is established, a treatment plan is developed through a process referred to as “evidence-based medicine” (EBM). EBM is defined as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients”.

As it was originally outlined in 1992, EBM involves the following steps:

• precisely defining a patient problem and the information required to resolve it;
• searching the literature to identify the best studies;
• applying rules of evidence to assess the validity of the studies; and
• applying the evidence to the patient, being sensitive to the patient’s emotional needs.

EBM, now more commonly referred to as “evidence-informed decision-making,” is used to inform a treatment plan, but is not the only process at work in the development of the plan. Treatment plans are developed in concert with the values and wishes of patients and their families.

Over the past decades, the application of EBM has been facilitated through the development of techniques such as meta-analyses that enable the amalgamation of results of many randomized clinical trials, which are then translated into tools such as clinical practice guidelines. Nonetheless, the practice of EBM must also recognize individual variation in physiology and pathology as well as patient values regarding quality of life and other issues. Individual treatment plans must be followed-up and evaluated.

Accountability

The core accountability of the physician is to the patient. The physician-patient relationship is an integral one. Optimally, this relationship is based on absolute trust and openness and allows for a free exchange of information between patient and physician. Physicians often see patients at their most vulnerable, when they are struggling with illness and disease. While other health care providers make significant and sometimes essential contributions to patient care, none maintain the unique fiduciary relationships that are at the heart of the physician’s role, and which are recognized by law.

Physicians are accountable to their individual patients in many important ways. They provide clinical services to their patients and optimize service availability so that patients can be seen and their needs addressed in a timely fashion. They follow up on test results. They facilitate consultations with other physicians and care providers and follow up on the results of these consultations when needed. They ensure that patients have access to after hours and emergency care when they are not personally available. They are stewards of the patient’s medical record and protect the confidentiality of the patient’s personal health information.

In Canada, physicians are held to account by the Colleges of Physicians and Surgeons in every province and territory. These regulatory bodies are responsible for the licensure and discipline of the medical profession. The colleges are in place to protect the interests of the patient and they are governed by a combination of public representative and physician directors.
It is increasingly recognized that physicians have an accountability to society and the health care system given that they hold responsibility for the majority of decisions surrounding the allocation of health care resources. This accountability is monitored through a variety of mechanisms including institutional review committees and payment agency audits.

With health care accounting for roughly one-tenth of economic activity in many industrialized countries, physicians are being called on to make the most efficient and cost-effective use of scarce resources. Cost is increasingly being recognized as an important element of value in health care. More generally, value is defined with reference to cost, such as “the worth of something compared to the price paid or asked for it.” Hence, Porter adds that value is defined as outcomes relative to costs, i.e., efficiency. The cost dimension of value is most likely to be addressed at a societal level, particularly in a system of universal publicly funded coverage. More recently, efforts are underway to bring value considerations into clinical decision-making. “Choosing Wisely” is one such initiative in which specialty societies are developing “Top 5” lists of tests and procedures that are relatively expensive and which have been shown by evidence to be of little or no benefit for a significant proportion of the patients for whom they are ordered.

Choosing Wisely Canada was launched in April 2014.

Conclusion

Looking ahead there is an increasing demand for “social accountability” across society, including the business, public and civic sectors. Social accountability is a term that describes the process of how an organization engages with the society it serves to meet societal needs. For example, the World Health Organization defines the social accountability of medical schools as the “obligation to direct their education, research and service activities toward addressing the priority health concerns of the community, regions and/or nation they have a mandate to serve.” However, as it has been defined, the concept of social accountability needs to go farther.

It is recognized that physicians are granted a significant degree of social status, and clinical authority and autonomy within the health care system. In return for this status and authority, as part of what is often referred to as the “social contract,” physicians are accountable for the quality of care they provide to patients. All of this takes place within the ever-changing environment of team-based and patient-centered care. There is concern that there has been an erosion of accountability to the social contract on the part of physicians, evidenced by falling perceptions of physician value when compared to other health professionals. The medical profession must not fail to uphold its end of the social contract, and organizations such as the CMA have an important role to play in ensuring that physicians continue to advance the cause of medical professionalism as the society in which we work changes and evolves.

In conclusion, our research has told us clearly that the public views the medical profession as being unique in terms of the breadth of expert medical knowledge and also in terms of the degree of accountability to the patients themselves. The intensity of medical training, the continuous upgrading as new information becomes available, and the application of the best treatments available has made physicians stand out from other health professions. In addition, the educational, professional and legal oversight of physicians throughout their careers puts physicians clearly foremost in terms of the level of scrutiny to which the medical profession is subjected. In times when there are many players in the health care realm, the communication of these strengths to the public can ensure that patients and governments are in a position to place their trust in health care providers who offer effective care and who take unparalleled responsibility for their patients’ health.
Strategic questions

1. Do we understand sufficiently the unique value of the patient-physician relationship as it is seen through the eyes of the patient?
2. How should the physician unique value proposition be cast in the emerging environment of team-based care?
3. Is the continued reliance on fee-for-service undermining the physician value proposition in the emerging context of team-based care?
4. What does social accountability mean to the individual practicing physician and to medical organizations and is it an essential element of medical professionalism?
5. How will health care transformation enhance the physician unique value proposition?

References

7. See http://multipleminiinterview.com/
8. Liaison Committee on Medical Education. Functions and structure of a medical school. June 2013. [Website], Accessed 02/03/14.
12. Federation of Medical Regulatory Authorities of Canada. Physician revalidation. [Website], Accessed 02/03/14.