have certainly changed, but not for the reasons suggested by Dr. Chan and colleagues in the article on fee code creep and another article in the same issue, "High-billing general practitioners and family physicians in Ontario: How do they do it? An analysis of practice patterns of GP/FPs with annual billings over $400 000" (*CMAJ* 1998;158[6]:741-6). Did the authors consider the possibility that physicians now claim for more intermediate than minor assessments because patients no longer return a few days after an office visit for re-assessment of their response to treatment? Nowadays, the patient is instructed to return only if the condition worsens or there is a failure to respond as expected.

This change has occurred for several reasons: sometimes it is because the family physician is attempting to reduce the cost to the health care system; in other cases it is because the physician has had to accept many more patients into the practice than he or she would like and there is simply no time to see patients for follow-up.

How do high-billing family physicians in Ontario do it? By working 80- to 100-hour weeks, by working in emergency departments and walk-in clinics in their "spare" time, and by other similar means.

Wendy Mitchell-Gill
Oshawa, Ont.

"Creep" is a delightfully appropriate word, reminiscent of school days. It makes me think of some teachers who, observing the tendency for gradually increasing unruliness in their classrooms, would lower the boom and quickly restore order. If our health care system is to remain viable, some decisive action over and above what Dr. Charles J. Wright, in his editorial "Practice patterns and billing patterns: Let's be frank" (*CMAJ* 1998;158[6]:760-1), characterizes as "remarkable statesmanship" would seem to be required to determine the true worth of services rendered and to counteract the destructive trend toward charging what the market will bear.

Although Dr. Chan and colleagues feel that "[t]he underlying cause of creep remains a mystery," other observers might be equally mystified by the lack of any reference to the "g" word. Is it possible that greed is not applicable in the sanctified sphere of Canadian physicians?

William D. Panton, MD
Burnaby, BC

The reason for the observed 10-fold increase in the ratio of intermediate to minor assessments performed by Ontario GP/FPs (the lowest-paid group of physicians in that province) is that these physicians have not had a meaningful increase in their fee schedule for many years. During this time, overhead costs have risen substantially, and the Ministry of Health continues to claw back a portion of billings. It has been a matter of trying to "stay afloat," to earn a reasonable income for the time and effort spent caring for patients.

William B. Hanley, MD
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Division of Clinical Genetics
The Hospital for Sick Children
Toronto, Ont.

[One of the authors responds:]

First, let me address Dr. Richardson's suggestion that investigators are unaware of the concerns of frontline physicians. As a scientist who stays in contact with clinical medicine by doing locum tenens, I have had the opportunity to work in more than 50 family physicians' offices and emergency departments over the past 9 years. My interest in this topic arose from my observation of the huge differences in how physicians code their office visits, without any clear relation to the services provided. This observation has been confirmed by a recent McMaster study, which found wide variation in the billing patterns of physicians who saw the same standardized patients.[1]

In response to Dr. Wells's question about funding and potential bias, I would like to point out that this study was paid for exclusively by the Institute for Clinical Evaluative Sciences. Our results were provided in advance to various joint Ontario Medical Association–Ministry of Health working groups dealing with fee schedule reform, and our analysis was well received by both sides as objective and informative.

Ms. Mitchell-Gill suggests that fee code creep occurs because patients are being discouraged from returning for re-assessment because of physicians' increasing workloads. The logic of this argument is unclear: if physicians' workloads are expanding, the response would more likely be to perform shorter (i.e., minor) assessments; indeed, this is what we saw among physicians with a high volume of office visits. Perhaps Ms. Mitchell-Gill's point is that follow-up visits, which tend to be minor assessments, are being eliminated with the increasing patient load. However, this assertion is inconsistent with the data, which indicate that the number of intermediate and minor assessments *per patient* has risen substantially, from 2.7 in 1981/82 to 3.6 in 1994/95 (values based on a re-examination of our data). Patients are getting more follow-up from their physicians over time, not less.

The letters prompted by our articles provide an interesting counterpoint: one of them notes that our paper on fee code creep is excessively cautious and avoids the "g" word, whereas another criticizes the reference to supply-induced demand and the potential for physicians to "main-

tain their incomes" through coding practices. Perhaps this is the best time to address the question that appears to be on many readers' minds: Is fee code creep the result of physicians trying to give themselves a raise? The letters from Drs. Richardson and Hanley do not quite suggest this, but they do suggest the similar hypothesis that doctors have been using their discretionary powers in coding visits to counter the downward pressures on their incomes. Weighing against this hypothesis, however, is our observation that fee code creep occurred long before the expenditure caps of the 1990s. Indeed, the fees for intermediate and minor assessments rose by 2% to 3% per year between 1981 and 1988,[2] even after adjustments for inflation in the health care sector,[3] yet the ratio of intermediate to minor assessments (I–M ratio) rose by 10% per year during the same period.

I would argue that searching for greed as a motive is unproductive. An

Diagnosis of chest discomfort simplified

In this letter I describe 2 easily performed yet effective diagnostic tests for patients who present with chest pain. The first, which I refer to as the "sternal pressure test," is particularly helpful for women with atypical chest discomfort with or without dyspnea. Such patients frequently report discomfort and dyspnea associated with using the upper body musculature (e.g., making beds or carrying heavy items) or positioning the arms over the head (e.g., putting articles away on high shelves).

The test is conducted as follows. The physician places one hand over the upper third of the sternum, supports the back with the other hand (Fig. 1) and then exerts light pressure over the sternum for approximately 10 seconds. The test may be repeated with the hand placed over the middle third of the sternum. If the patient complains of dyspnea, discomfort, a choking sensation or a sense of suffocation during the test, the result is considered positive.

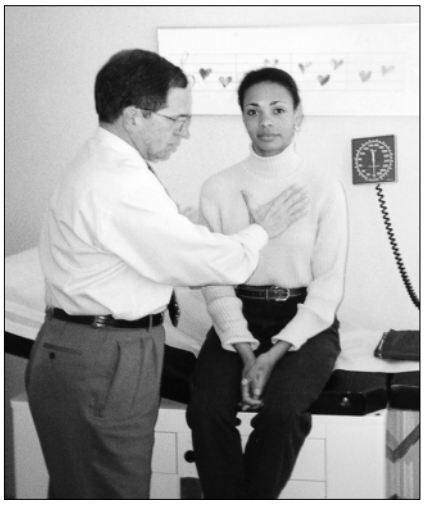

Fig. 1: The sternal pressure test.

Recently I have tried to quantify the results of this test by placing a partially inflated blood pressure cuff between the sternum and the palm of the observer's hand. In patients with a positive result, it is seldom necessary to go beyond 25 to 30 mm Hg pressure to elicit a response.

I believe this test could become an integral part of the physical examination of women (and perhaps some men) with atypical chest pain and dyspnea.

The second test is the "15-second CPS test," which is conducted as follows. The seated patient is instructed to hold the hands together in front of the body at eye level, with the palms up. There should be only a slight flexion of the elbow (Fig. 2). The *Compendium of Pharmaceuticals and Specialties* (CPS) (or any other large book weighing about 2 kg) is then placed in the patient's outstretched hands. The patient is asked to maintain the book at that level for up to 15 seconds and to describe any symptoms that develop.

Patients, particularly women, whose chief presenting symptoms include chest pain or dyspnea are frequently unable to hold the book in position for longer than a few seconds, which is considered a positive result. Even those who can hold the book in the designated position quickly begin to report dyspnea, choking, and back, arm, shoulder and retrosternal pressure as well as a sensation of oppressiveness or suffocation and even palpitations and sweating. A positive result is rare in men.

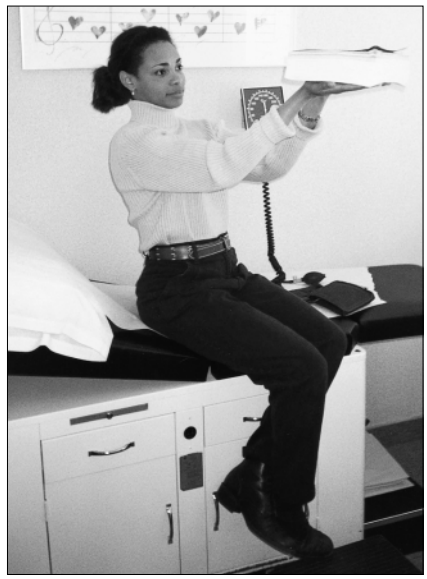

Fig. 2: The 15-second CPS test.

Although a positive result for either of the tests described here does not imply the absence of other sources of discomfort, it certainly raises the possibility of a chest wall cause. I hope that others will carefully evaluate both of these procedures to determine their usefulness.

R.S. Baigrie, MD
Sudbury, Ont

alternative hypothesis is that the vagueness of the definitions of intermediate and minor assessments may lead physicians to use the mean I–M ratio as a de facto standard. Each time the mean shifts upward (for example, as recent graduates with higher I–M ratios enter the system), the de facto standard also shifts upward. Physicians with lower I–M ratios might examine the mean and conclude that their definition of an intermediate standard is more conservative than that of their peers and raise their I–M ratios accordingly. This behaviour may reflect not inappropriate motives but simply a desire to be treated fairly. Nonetheless, the result is a continually increasing de facto standard. As one family practice colleague suggested to me, the billing profiles that the Ontario Health Insurance Plan sends to each physician may, ironically, be contributing to fee code creep.

An analysis of these group dynamics would make for an interesting dissertation for a psychology major but would not alter the key message of our study: we need clearer guidelines as to what constitutes an appropriate office visit. The demonstrated variation in I–M ratios suggests that there is no consensus on the basic issues of how much time a physician should spend per patient visit and what is an appropriate level of detail for the visit. Some physicians have high-volume practices with brief visits, others have low-volume practices with more detailed visits. Which is preferable for our patients? It is high time that we, as a medical profession, did some hard thinking about the model of care we should be encouraging.

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2. *Schedule of benefits: physician services under the Health Insurance Act* (versions 1981 to 1988). Toronto: Ministry of Health; 1981–1988.
3. Statistics Canada. *Consumer prices and price index*. Cat no 62-010-XPB. Ottawa: Minister of Industry; quarterly.

Editor's note: In addition to the letters published here, we received at least one unsigned letter commenting on the articles by Dr. Chan and colleagues. Although we will consider protecting the identity of correspondents in certain circumstances, we do not publish anonymous letters.

Paying physician managers

In the article "MDs aiming for hospital boardroom may face humbling experience, CEO warns" (*CMAJ* 1998;158[7]:918-9), it was a pleasure to see a balance in the description of Dr. Jeffrey Lozon's approach to administration and management activities by physicians. Just as physicians need to change from a quarterback role to a management role, in which they communicate as equals, it is also important for managers to treat physicians as equals.

The notion that physicians are to be equals in leadership roles but to work as volunteers in these duties has always been a poor concept, and I am glad that Lozon recognizes this by compensating his program managers at St. Michael's Hospital.

Physicians will continue to donate their time to worthwhile endeavours such as hospital boards and committees, but not all of their duties outside direct patient care should be performed gratis.

Patrick J. Potter, MD
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Abortion in proportion

There is an inaccuracy in the Pulse column dealing with "Abortion and the married woman" (*CMAJ* 1998;158[7]:992), by Lynda Buske. She states that "Canada's abortion rate for these women is about average" when compared with the rates in other nations. However, for these comparisons she uses data on the *proportion* of married women receiving abortions in 5 other nations, not data on abortion rates. The proportions mentioned in the article are meaningless without the rates.

Islam Mohamed, MD
Cross Cancer Institute
Edmonton, Alta.

[The author responds:]

Canada's comparative ranking in terms of the proportion of therapeutic abortions involving married women should not have been described as a rate. The point being made in the paragraph in question is that the proportion of women receiving abortions in Canada who are either married or in common-law relationships, about 25%, is not unique in international terms.

Lynda Buske, BSc
Chief, Physician Resources Information and Planning
CMA

Perverse incentives for all

In his editorial "Practice patterns and billing patterns: Let's be frank" (*CMAJ* 1998;158[6]:760-1), Dr. Charles Wright demeans Ontario physicians who prefer fee-for-service billing by implying that only they are susceptible to "perverse incentives."

Most physicians, whether paid through fee for service or an alternative payment plan, provide an appro-