About those US fees . . .

In a recent article by Charlotte Gray ("MD crosses great divide when moving between practices in Canada, US," *Can Med Assoc J* 1996;155:1599-1600), plastic surgeon Dr. Robert Harris compares medical practice in Canada and the US. The only complaints he describes are purely economic: higher overhead costs and insufficient compensation in Canada.

That US overhead is lower is at best improbable, especially given the very high malpractice fees in New York. As for compensation, the 2 conditions he cited (breast reduction and mole removal) are not compensable by either Medicare or private insurance unless there are medical, rather than cosmetic, indications.

Harris said he is paid "several hundred dollars" for "a simple mole removal." This is both unlikely and outrageous. Most private insurers pay the same or slightly more than the Medicare "allowed" schedule. The 1997 Medicare "allowed fee" for excision of a benign mole between 0.6 cm and 1.1 cm is $79.42 if it is on the face and $64.05 if it is on the trunk, arm or leg. Harris also claimed that he "earns between $2500 and $4000" for a breast reduction. The Medicare fee is $1260.13.

I have recently been privileged to observe the practices of fellow dermatologists in Calgary. They too have complaints and discuss improvements they would like to see in your health care system. But neither they nor their patients would abandon its principles, as spelled out in the Canada Health Act.

I do not doubt that the incomes of many orthopedists and cardiovascular surgeons is higher in the US, but this is changing. US physicians are losing their professional autonomy — and, yes, income to boot — to the managed-care industry. Managed care promises, *inter alia*, protection from the exorbitant charges of "entrepreneurial types" (Gray's well-chosen term). Instead of inviting the managed-care fox into their medical hen house, my Canadian colleagues should instead mend the defects within their system.

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[Dr. Harris responds:]

I can categorically and unequivocally state that the fees paid in New York State for the 2 items in question are, contrary to Levan's inference, in no way exaggerated. I enclose a copy of a statement from an insurance company for a patient who underwent removal of a dysplastic nevus from the face. [*CMAJ* has this statement on file. — Ed.] The total payment was US$375, $250 for the surgery and the rest for preoperative and postoperative visits. The equivalent fee in Ontario would be Can$86.70 (before clawback).

In the 11 years I have been practising in upstate New York I have never been paid less than US$2500 by a private insurer for a bilateral breast-reduction operation once permission for the procedure has been granted. Approval is based on patients' complaints of upper-back and shoulder pain and disturbed posture. If the procedure is considered a reduction mammoplasty rather than a simple breast reduction, the fee can be as high as US$4000.

Another example: carpal-tunnel release in Ontario pays Can$144 (before discount), whereas the going rate in New York is US$550, exclusive of visits. Because of the different values of the 2 currencies, the discrepancy is even greater than it appears.

My point is to emphasize what an incredible bargain the Ontario Ministry of Health is getting from its physicians. It is their unselfishness and devotion that have kept the system working all these years, and they are certainly justified in their long-overdue voicing of concern about the financial shortchanging they and the health care system have experienced, especially in the past decade.

Levan is correct in stating that managed care is growing in popularity in the US. In my case, however, this has been a boon, because I have signed up with several of these insurers and my patient clientele has increased as a result. Finally, because of geographic risk differences, my malpractice insurance is roughly equivalent to that in Canada (US$13 200 vs. Can$16 020).

Practising medicine today is not nearly as agreeable as it once was, but in the US the physician–patient bond still exists. In Canada, health ministry prerogatives often take precedence over the patients's best interests. In any event, that has been my career experience.

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A detailed comparison of physician fees in the US and Canada is found in the Pulse column, page 960. — Ed.

Time for the CMPA to reward malpractice-free MDs?

I read with great interest the conclusion of the article "GP/FPs and the delivery of babies" (*Can Med Assoc J* 1997;156:144), by Lynda Buske. The author drew a correlation between the opening sentence and the

conclusion. None of us who continue to practise obstetrics has seen a "significant enough" caseload to warrant paying the higher Canadian Medical Protective Association (CMPA) dues. The caseload fluctuates from year to year. The present fee structure of the CMPA does not seem to reward or recognize those GP/FPs who have had a clean record. In every other insurance scheme, only the members with repeat convictions or claims face a stiff, heavy penalty in their premiums. The CMPA's fee structure penalizes the whole group *en masse*, so that all members are continually paying for the errors of others. The CMPA should consider introducing a "no-claim bonus" for members who have had a litigation-free practice. The present system is very unfair and will continue to deter new GP/FPs who wish to practise low-risk obstetrics.

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Disability forms and third-party reports

I found the article "Disability payments continue to climb: 'Tell us what you see, not what you think,' CPP tells MDs" (*Can Med Assoc J* 1997;156:61-4), by Nicole Baer, quite informative. To those of us in the trenches, it has seemed that requests for disability forms and third-party reports have been increasing, and the exact burden on the Canada Pension Plan (CPP) is indeed impressive. The article also struck an important chord in its description of the fundamental alterations of the physician–patient relationship once a disability form enters the equation.

It is important to point out, however, that the statement "Just the facts, please" is inappropriately simple. Much of clinical medicine relies on the patient history. In every clinical encounter physicians covertly or overtly judge how reliable that patient history is. Rarely do we assume that the patient is deliberately misleading us. The relationship is one of trust. We trust the patient to give us enough clues to arrive at an appropriate diagnosis, and they trust us to recommend reasonable and appropriate therapy based on that diagnosis. This works well until there is obvious secondary gain for the patient, but patients who intend to mislead are rarely obvious. Frequently we suspect that the patient might be misleading us when the current history conflicts with other facts we have gathered about the patient. Often these are intimate personal details that were divulged in privileged prior clinical encounters, which were based on trust. Should this privileged information be passed along to third parties?

In addition to this, we can rarely test the accuracy of a patient's statements of function through an ordinary office encounter. We may find that a shoulder moves normally, with minimal pain, when we examine it, but of what relevance is such a finding to an electrician who complains that his arm goes numb when he works with his hands above his head for more than 20 minutes? Likewise, we can assess grip strength but we have no adequate way to test whether a patient can function in the kitchen, as I suspect few physician's offices are equipped with the saucepans and utensils needed to conduct such a test.

Physicians are frequently and inappropriately asked to extrapolate from simple office manoeuvres in making assessments of function that will determine a patient's eligibility for disability payments. We are also inappropriately asked to judge the severity of this loss of function. And we will continue to be asked because we, as a group, are far too willing to provide such opinions, even though the setting provides limited and flawed information. Do disability carriers not have a duty to develop simple, reliable and accurate clinical tests that can be completed in the physician's office to aid in making these decisions?

In the meantime, it is the physician's duty simply to report the facts, "as the patient reports them." Physicians should not have to judge the veracity of patients' statements. As well, until there are some agreed-upon methods that all physicians can use, we should not have to make arbitrary extrapolations about function based upon simple clinical tests.

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Drug packaging

The letter on drug-labelling confusion, "Over the counter and into trouble" (*Can Med Assoc J* 1997;156:17), by Dr. Catherine Younger-Lewis, made me wonder how a human-factors consultant might approach this problem.

May I offer 10 drug-delivery principles that I think apply?

1. Labelling
   Package labelling should be clear and unambiguous, with readable fonts and sharp print contrast.
2. Warnings
   Special instructions or warnings should be highlighted and prominently displayed on the packaging (e.g., May be sedating — avoid operating heavy machinery).
3. Product identifiability
   All products should include a product code, lot number, expiry date and suggested route of administration. In addition, tablets should have unique markings to allow product recognition.
4. Generic name