



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
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"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 states-

manship" 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?

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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.

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[One of the authors responds:]

First, let me address Dr. Richardson's suggestion that investigators are unaware of the concerns of front-line 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-