Letters
Correspondance

Understanding the audition

I commend Dr Kirkwood for raising the issue of patient "auditions"[1] in a forum where the topic can be discussed by family doctors across the country. I offer the following comments in the spirit of extending the "fruitful discussion" on this subject that Dr Kirkwood has initiated.

The first point to be clarified is whether patient "auditioning" is, in fact, occurring. Anecdotally, patients in the office and emergency room have informed me that this does happen. Patients themselves, however, are not in a position to know why they are still without family doctors (although they might assume that elements of their medical history have worked against them): perhaps a random selection took place and they lost out. On the other hand, the fact that detailed medical information is requested strongly suggests that it is playing a role in the patient selection process (if it isn't, one wonders what a privacy commissioner would have to say about this collection of information). The close attention to this issue paid by both the College of Physicians and Surgeons of Ontario[2] and the Ontario Human Rights Commission[3] also supports the view that these are not isolated occurrences. Only limited public information about how physicians actually use these patient applications is available[4]; perhaps those family doctors who employ this process should go on record with a description of how it works.

Although we might lack firm evidence of exactly what is happening in these patient-selection events, there is one factor that provides a plausible explanation for the rise of the "audition." Over the past few years (I speak from my own experience in Ontario) patient capitation systems (in which physicians are paid primarily by fixed rates for the patients they have on rosters, rather than for medical services provided) have been strongly promoted by the provincial government, and incredible effort has been expended in making them financially attractive to physicians. It requires only elementary mathematics to understand that being paid a monthly fee for a patient you are unlikely to see (ie, a healthy patient) is better compensation than being paid that same monthly fee for a patient who could require multiple monthly visits (ie, a sick patient). Therefore, a capitation system provides a perverse incentive to "stack" the roster with healthier patients—maximizing revenue and minimizing work. Whether or not this factor plays a role in an individual physician's decision to "audition" patients is impossible to say, but it would be naïve to ignore the possibility.

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by Rapid Responses

References

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2. College of Physicians and Surgeons of Ontario. *Establishing a physician-patient relationship* [draft policy]. Toronto, ON: College of Physicians and Surgeons of Ontario; 2008. Available from: **www.cpso.on.ca/Policies/consultation/Establishing%20_Draft.pdf.** Accessed 2008 Jul 11.
3. Ontario Human Rights Commission. *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario regarding the draft policies relating to establishing and ending physician-patient relationships.* Toronto, ON: Queen's Printer for Ontario; 2008. Available from: **www.ohrc.on.ca/en/resources/submissions/surgeons.** Accessed 2008 Jul 11.
4. Chaudhary O, Goldman, B. *White coat, black art* [podcast]. Toronto, ON: Canadian Broadcast Centre; 2008. Available from **http://podcast.cbc.ca/mp3/whitecoat_20080219_4726.mp3.** Accessed 2008 Jul 11.

Casting stones

The article provocatively entitled "Casting call"[1] states its goal to be the initiation of a fruitful discussion regarding the practice of interviewing potential patients before the establishment of patient-physician relationships. Its emotionally loaded terminology, limited ideas, and arrogantly judgmental tone, however, do not promote constructive conversation.

The title and phrases such as "auditioning," "application-and-approval process," "physicians choosing patients to suit their own desires," "dereliction of duty," and "ethically abhorrent" are all inflammatory, diminishing the likelihood of achieving progress in this matter.

The article stresses the idea of duty, but misapplies and flogs it to the exclusion of other important, relevant ideas. Whereas the physician's duty is to her patient, the article sounds as if the doctor's duty is to accept everyone as patients. The article fails to recognize that a substantial part of family doctors' work is in the areas of prevention, prospective care, and care of chronic conditions. In these areas, health optimization is a team effort with the patient as the captain. And it is especially in these areas that the doctor-patient marriage can either be a frustrating duel or a mutually satisfying duet. It makes every sense to have at least a rudimentary courtship before such long-term bonding. Even in less constrained physician-supply conditions, an interview to see how well the prospective partners would work together is sound.

Further, the article does not consider the complex mosaic of duties that those who practise family medicine must fulfil. The article fails to take note of the issue of physician burnout. It ignores the numerous health care system issues and duties. As the article lacks intellectual comprehensiveness and balance, it promotes polarization and politicization and inhibits problem-solving behaviour.

The article tenuously links distorted sketches of precommitment interviews, physician shortages, physicians' desires, and marketplace maneuvering, among others, in order to arrive at the damning caricature presented in its final climactic statement. If this article achieves