Analogy does not apply

Dr Ladouceur's restaurant analogy in his May editorial[1] is inapplicable and nonsensical. Restaurant owners set their own "fees" to cover their costs and increase them based on market forces and cost increases. A third party determines the fees for physician services and, most importantly, determines which of those services are covered. The third-party payer has no interest in educating the customer as to what is covered and leaves it to the physician to either absorb that cost or pass it on to the consumer. Furthermore, goods and services in Canada are laden with hidden costs. The advertised price has goods and services and provincial sales taxes added after the fact and, if a restaurant, gratuity is not included.

It is a fact of human nature that services provided for free are devalued and become expected. Just as taking the time to explain why an antibiotic prescription is not necessary decreases re-presentations expecting antibiotics, educating patients (and employers!) on the costs of what is not covered by Medicare decreases unnecessary repeat requests that creep into the publicly funded domain. By instituting an automated recall system *and* charging for no-shows, our clinic has dramatically decreased no-shows and thus decreased wasted appointments and improved accessibility. Not charging (fairly) for uninsured services and not reinforcing to patients that there is a cost for not showing up for their appointments perpetuates the unsustainable delusion that Medicare should "just pay for everything." This actually increases costs to the public purse and threatens the sustainability of publicly funded health care.

—Paul V. Mackey MBBS CCFP CAC(FPA) FCFP
Fort St John, BC

Competing interests
None declared

Reference
1. Ladouceur R. Extra fees for uninsured services. *Can Fam Physician* 2016;62:373 (Eng), 375 (Fr).

Medicine is a business

While I get a chuckle out of Dr Ladouceur's rose-coloured view of the business of medicine[1] (and make no mistake, it is most definitely a business), his public condescension toward colleagues seems to be ongoing,[2,3] so I feel I must respond.

First, to his point about charging for missed appointments, in my experience most physicians advertise these penalties but rarely enforce them. If I missed a dentist appointment, I would be charged; if I wasn't home to open the door for the plumber, I would be charged; and a doctor's office is no different, in that it is time wasted for the business. If I had a patient who missed multiple appointments without a reasonable explanation, I would not hesitate to ask them for compensation for my time.

To be clear, I run a business trying to maximize profits, and yet I care deeply about each and every patient I see and I work my hardest to do right by them. What Dr Ladouceur seems to miss is that these goals are not mutually exclusive. Just like most every other business, there is a market rate for my services. In recent years, government fee schedules have not kept up with the market rate for these services, and certainly have not kept up with changes in technology and innovative service delivery models, and so in talking with my colleagues, we feel increasing pressure to fill this gap by billing for services that previously went uncompensated. My own professional interest is in innovation in service delivery in family medicine (for example, how many patients in Canada can freely send an e-mail or text to their physicians?), and as fee-schedule changes are inherently conservative, this type of innovation will necessarily come from user fees, with the hope of being included on the fee schedule once proven. My patients are free to shop around for a family physician, and all fees are published up front and before service delivery. I refuse to be made to feel guilty for asking to be compensated appropriately for my services.

—Brady M. Bouchard MBBS CCFP
Victoria, BC

Competing interests
None declared

References
1. Ladouceur R. Extra fees for uninsured services. *Can Fam Physician* 2016;62:373 (Eng), 375 (Fr).
2. Ladouceur R. Where is family medicine heading? *Can Fam Physician* 2015;61:1029 (Eng), 1030 (Fr).
3. Ladouceur R. Thou shalt not kill. *Can Fam Physician* 2015;61:301-2 (Eng), 304-5 (Fr).

Professionals, not employees

When I read Roger Ladouceur's editorial,[1] I felt a flush of resonance and strong emotion because he's raised an issue that is dear to my heart and that has dogged my clinical life for 4 decades.

Since beginning practice, I have struggled with charging individuals fees for so-called uninsured services, and have undercharged, or not charged at all, on by far most occasions. I have never been able to look someone in the eye (or compelled my staff to do so) and tell them to pay a fixed sum for a service, knowing, for example, that their material life is dependent on a welfare cheque or other modest or even desperately meagre fixed income. Nor have I been able to charge a sum for a routine note that takes me 3 minutes to write, or a form for a student health clearance that requires only a signature, or any of myriad daily acts that occupy my professional time. I don't ever charge for sending records to other physicians because—for heavens' sake!—this is how continuity of care, that estimable prize of good clinical practice, is maintained.

In fact, when patients come in perplexed because they've received a bill for, say $30 to $50, from a physician they have seen 10 times and who has performed only perfunctory care for modest health issues, I encourage them to ignore it.

Subversive on my part?

I don't think so. I think it's realistic and honest. People in many jobs, especially on a fixed salary, do just as many routine tasks as we do, and the costs are folded into their overall wages. We physicians, handed fee-for-service earnings on a platter, have started to believe that every little thing we do is worth recompense.

Several commentators have said "medicine is a business," suggesting Dr Ladouceur is naïve. One even went so far as to claim that not charging reinforces patriarchy[2] (quite a challenge for female practitioners, I suspect), as if absorbing the costs of uninsured services was somehow demeaning to patients. I would point out to her, and to many others, that charging extra for more and more things is a relatively new phenomenon, and more a reflection of a general corporatization of social mores (with a little help from Reaganomics and the World Bank's infamous policy of structural adjustment, where privatization is a god) than it is a reflection of our work.

In making comments like these, I fear we forget several critical aspects of what we do.

First, our earnings, for the most part, come not from our patients, but from the public purse. Most practitioners get most of their cash simply by filling in a form or making a data entry, and behold, the cheques are deposited in our accounts without fuss. We are paid from taxes paid by all citizens.

That means what we do is *not a business*. It is a public service, delivered by us in this fashion because society has decided, in its collective (and increasingly eroded) wisdom, that what we do is essential enough to the well-being of others that we should receive automatic compensation for what we do. Lawyers don't get paid like that. Scientists in discipline after discipline don't get paid like that. Almost all of our patients don't get paid in that automatic, secure way.

Calling what we do a business, under those circumstances, is illogical and *truly* naïve. If any practitioner feels otherwise, then read the business literature. It's all about profit, loss, layoffs, downsizing, efficiency, "trimming" the work force (ie, firing or laying employees off) depending on market fluctuations, moving production overseas to cheaper and less regulated work environments, etc.

Physicians, almost across the board, are insulated from all those business realities. But there's more. We can't be downsized (a few operative specialists can be in some measure, but only in part). We can live where we want; we can practise as much or as little as we want; we can focus our work on areas that interest us; we can organize our practices in the way we find most convenient.

And by and large, compared with Canadians in just about any other occupation, we cannot be fired for anything besides indecent, immoral, or illegal behaviour. I would be the first to say that the colleges (the provincial ones that license) can be a bit starchy in the way they deal with clinical outliers, especially those who branch out into nonpharmaceutical remedies, but that's another story.

Second, and derivative of the first point, we get these privileges because we call ourselves a self-regulated profession. *Self-regulated*.

That means that what we do as doctors is assessed and judged and regulated, for the greatest part, by other doctors—not by our patients, not by government regulators (they can control the fee schedule and infrastructure, but they don't assess our clinical behaviour). We guard this privilege of self-regulation with great fervour, unwilling to let anyone tell us how to actually practise. That's because we believe that the social contract that gives us this attribute is our right—but society acknowledges that *right* only if we exercise a parallel *responsibility* to act in the public good.

I have long contended that if we don't take seriously our responsibilities—and a few modest sacrifices—to act consistently in the direction of achieving a public good, then society will be inclined to withdraw our self-governing status and turn what we do into just another job, with increasing restrictions, rules, and more of the standard employee vulnerabilities. Like other government employees, we will be told where to work, how to structure our clinical activities, what hours we can adopt, and if we will have to be let go because there are too many of us and our services are not valuable enough to be affordable.

Finally, we can all charge for services that are uninsured, but who we charge for them is critical. Charging large and profitable enterprises like insurance companies or legal and other third-party representatives whose fees are truly profit-oriented, or charging for a substantive

effort (like a long letter in support of a patient's personal needs, sent to a social service agency), is and always has been acceptable. I am not a billing nihilist.

So ...

Do I think we should charge for uninsured services? Yes, occasionally, and in concert with our fundamental principle of primum non nocere. Our actions in charging for services are not neutral or without effects. To see what we do as being part of a "business model" is, however, in my opinion, to negate the principles under which we work and, at worst, represents simple opportunism.

—Warren Bell MD CM CCFP FCFP
Salmon Arm, BC

Competing interests
None declared

References
1. Ladouceur R. Extra fees for uninsured services. *Can Fam Physician* 2016;62:373 (Eng), 375 (Fr).
2. Mazerolle M. Supposed altruism can be the facade of the patriarchy [Rapid Response]. *Can Fam Physician* 2016 May 17. Available from: **www.cfp.ca/content/62/5/373/reply#cfp_el_14931**. Accessed 2016 Jun 9.

Create a better system

Dr Ladouceur[1] has described a practice that has become so common in medicine that it is rarely commented on—charges for uninsured services related to health care, such as parking, sick notes, and other forms. Although a hardship for many, fees are now the norm. This is unfortunate, as research has made clear that fees create a barrier to health care, particularly for the most vulnerable. Although the services provided by a hospital or a family doctor might be covered by Medicare, the additional charges could deter those seeking care.

Family doctors are undoubtedly being asked to take on additional work, such as filling out forms, for which they are not compensated. Many doctors pay high fees for running their offices—and they also likely waive fees for patients when asked. However, many patients likely suffer without asking—or simply don't access care.

Medicare is publicly funded because health care is a collective benefit. When there are gaps in the system, the patient should not be made to fill them in with costs that might cause harm to their health. Instead, we can advocate to do away with unnecessary requirements such as sick notes and some forms, and we can seek ways to have uninsured services that are essential to patient health be included in our health care system

—Monika Dutt MD CCFP FRCPC
Sydney, NS

Competing interests
None declared

Reference
1. Ladouceur R. Extra fees for uninsured services. *Can Fam Physician* 2016;62:373 (Eng), 375 (Fr).

Make your views known!

To comment on a particular article, open the article at **www.cfp.ca** and click on the **Rapid Responses** link on the right-hand side of the page. Rapid Responses are usually published online within 1 to 3 days and might be selected for publication in the next print edition of the journal. To submit a letter not related to a specific article published in the journal, please e-mail **letters.editor@cfpc.ca**.

Faites-vous entendre!

Pour exprimer vos commentaires sur un article en particulier, ouvrez l'article à **www.cfp.ca** et cliquez sur le lien **Rapid Responses** à droite de la page. Les réponses rapides sont habituellement publiées en ligne dans un délai de 1 à 3 jours et elles peuvent être choisies pour publication dans le prochain numéro imprimé de la revue. Si vous souhaitez donner une opinion qui ne concerne pas spécifiquement un article de la revue, veuillez envoyer un courriel à **letters.editor@cfpc.ca.**