EDITORIAL

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Do what is needed; bill for it* (a Halloween hot take)

I was at a meeting about 10 years ago, at a session wherein the Ontario Medical Association urology rep highlighted upcoming changes to the fee schedule. The big reveal was that using a cystoscope and wire to skim past a urethral false passage could now be billed as "endoscopic urethral realignment of urethral trauma," a 185% bonus atop the consult/cysto/catheter baseline. I tell you it was the loudest cheer I heard until Oasis took the stage a few weeks ago. My first thought was, "Three-quarters of you trained under Ron Kodama," who would *wither* you with a stare and raised eyebrow as he watched you debase his decades' toil in Ontario's gnarliest perineums while you commit to scope-and-wire for every tricky Foley.

To this some will say, "Was there not trauma? Did I not align with my scope? Why do you want my family to suffer?" The fee schedule will continue to be more means-to-an-end and less a ledger of care delivery. For this month's take, I'm here to say that the ability to simply do things that needn't be done, to see people who needn't be seen, and to contort fee schedules via tortured semantics is so easy and so rewarding as to be a default mode of earning (and that this is not great).

I am, of course, sympathetic to the fact that earning as a doctor is underpinned by a lot of under-appreciated costs. I started practice at 34, saddled with comical debt like many of us. The opportunity cost of unearned savings in one's 20s is enormous when compounded. The debt is non-corporate, and its repayment gets taxed at the highest rates. No pensions or company RSP matching mean the golden years take their share from the working years. Association fees are well into five figures. Non-MDs will play their wee violins for us, but it really is not trivial.

Your schedule of benefits (or tariff or manual or such) is also a byzantine tome. Imprecise language, scattered and obscure add-ons for travel or time or location mean that you don't just get paid cleanly for a service. Your government has made these choices deliberately to sculpt and reward your work, but you have to work to interpret them. It would be foolish to adopt some moral stance or flippancy that sacrificed real dollars. If cream is on offer for services rendered, it ought to be yours!

Enough sympathy, time for the hot part. One could simply do appropriate work and bill the codes for it, but the siren song of codes=dollars is powerful. This leads to an epidemic of a) spurious work, and b) iffy interpretation to titrate one's income to one's own wishes, or self-image, or unwieldy lifestyle flywheel. You really can just keep seeing people and doing things.

The seeming paradox — and my contention — that patients generally value over-testing and over-surveillance is a convenient background for a host of unnecessary visits and investigations. Last Halloween, I bemoaned a "system built for maximum capture of long tail outcomes" and advocated "sunsetting of care when the value wanes."[1] A zero threshold to brandish the cystoscope at the top of the algorithm for every BPH and OAB and UTI consult (and then again and again to "monitor") is music to enough ears that we rationalize it as standard practice and cram our clinics with ultra low-value work.

In the clinic, funnelling every patient through the uroflow toilet and a quick bladder scan — useful for maybe 10% of folks — is a golden goose. I've heard tell of medical students stationed in so-and-so's clinic just for that purpose. *Ad infinitum* and curiously frequent surveillance of stable or cured patients, enough of whom *love* having a specialist on their calendar, is a low-friction annuity; I imagine two green bills drifting down like autumn leaves, just for strolling in to see a patient who could have been discharged years ago. The telemedicine revolution (a good thing!) has ratcheted up opportunity further. The density of patient interactions now has virtually no limits. A visit, then a call with the blood test results, then a call with the culture results, then a

call with the imaging results, then a visit to "lay eyes." Five codes for the work of two!

Creative (read: bad faith) interpretations, like "endoscopic urethral realignment of urethral trauma" are another goldmine. A ureteral stent is a foreign body, but not like *that*. The extra $90 in Ontario (jeez man, I did not know that until just now) sure helps with the linguistics issues though. Ambiguous wording around the size or "complexity" of a bladder tumor explains the mystery of the missing 1 cm or "simple" tumor from the OR. A uroflow is suddenly "multichannel urodynamics" because…just because. Complexity of codes is practically an invitation to pull out the coaxial dilators, sneak up to the kidney for a distal stone, punt until 17:05 to start a case, or remember a clinic visit as an exactly 51-minute slog.

Man, who cares? In a multibillion-dollar system, ragging on eight bucks here, a hundo there? For this hot take, I am indeed. Please understand that I am aghast at the amount of tax I pay too, and *clearly* our public institutions have many huge fish to fry when it comes to inefficient and wasteful use of tax dollars, but for today I'm not excusing over-extraction as benign just because the whole system is jacked. A thought experiment I like to chirp with: imagine these spurious cystos and unindicated uroflows as directly extracting the income tax haul from the entire staff of your hospital Tim Horton's. We seethe at the tax bill, then simply extract someone else's because we want it.

The prisoner's dilemma is a familiar game theory puzzle. Two players can cooperate to mutually benefit, or one can betray the other to take the spoils. The loser, who trusted the exploiter, comes away with what is known as *the sucker's payoff*. This seems an apt way to describe the moralizer who fastidiously bills and practices as by-the-book as they can. Why be the dope denying themself spoils when the hive mind accepts a little creativity here and there?

There are a couple of helpful models to explain why small variances can mean disease in an entire system. The first is a familiar term, *the tragedy of the commons*. In this parable, let's say a large pasture is shared by 100 farmers, each with 10 head of cattle. If farmer 61 decides to pop an 11th cow on the commons, the field has to sustain 0.1% more grazing (hardly a few blades of grass) while farmer 61 gains 10% on his barely noticeable trick. The problem is that farmer 61 is hardly unique in his incentives and desires, and so every farmer is soon sneaking an extra cow or two onto the commons, which is rapidly overgrazed. All of the cows, and all of the farmers, suffer. The analogy to billing flourishes is clear; all of those dollars are fixed-pie system dollars.

The other we'll call the *Urologic Overton Window*. In the public discourse, the Overton window refers to the bounds of what is considered acceptable.[2] This is usually applied to what is in-bounds when discussing political topics. The idea is that the repeated platforming of extreme or fringe ideas — as happens on motivated news networks and social media outlets — shifts this window of "reasonable" action or thought. Imagine repeated interviews with flat-earthers or fake-moon-landing types as raising the status of those views as OK-to-hold. By casually flaunting sound practice, we make the excess of unneeded stone baskets or scopes or PVRs mundane, encoding waste and marginal integrity as normal.

The spirit of Halloween hot takes is to be provocative. There is lots of legitimate room for contemplating care delivery in the context of the available pay mechanisms. But when your internal voice says, "Did I not…?", you probably did not. If you find yourself thinking, "I know this guy's different, he needs another scope," he's probably not. When the urojet pops through a snug meatus just so, and you think, "Meatal dilation," maybe think again. There are lots of nuances in clinical work and thinking but *knowing what you just did* isn't hard. Let the fee schedule be cluttered; your mind need not be.

REFERENCES

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