EDITORIAL

Cancel half of your clinic visits*

(a Halloween hot take)

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Carl alights from town plenty early, headed to see you. He had a partial nephrectomy for a grade 1 clear-cell six years ago and an ultrasound four weeks ago. He's retired, so doesn't have to fuss missing work, but on his fixed income, the 90 km round trip and parking make a dent. The office is characteristically bustling, and when you make it in to see Carl, your rump barely ricochets off the chair as you say, "Hey Carl, good news! The scan looks clear, no signs of new or spread tumor. Let's do it again in a year." Off he goes. Parking lot, Costco, home. Your clinical sense tells you that the imaging was necessary, but did Carl really need to come all this way for *that*? Did he need *you* at all?

Recently I riffed on the inefficiency of most of our clinical interactions, but this month, I'll blast right past that with a modest proposal: most clinic appointments don't need to happen.[1] They could be replaced with a "👍" on a messaging service, a 90-second e-consult, or nothing at all.

We function in a public-payer healthcare system that ought to be accountable for its limited resources. This system intends to provide the widest breadth of quality care as possible within that envelope. It is also important to note that while this system writes the checks, it is not specifically concerned with any clinician's income or lifestyle. Refer back here if you become appalled as you read: the pool is finite and unnecessary care may deny necessary care elsewhere.

Back to Carl — he needs to know that his scan is fine, or not, or otherwise actionable. Surely, however, he doesn't always *need* to hear it in person, nor ought the system bear the full cost of overhead and remuneration attributed to such a fleeting exchange of month-old news. Same for a host of other visits. Referrals for simple cysts; incidental 3 mm calcifications on ultrasound; untreated LUTS; three UTIs in 18 months; bedwetting at age nine; a 10° penile curvature; a single PSA of 4.4 in a 72-year-old; a few disquieting hot pees; incidental microlithiaisis, and on and on. A sensible system would deflect these with quick advice before a urology consult ever happened. On the other side: endless post-treatment surveillance after TURP or lithotripsy, yearly check-ins for stable LUTS or the spectre of a UTI that hasn't recurred in years; a 14-year post-prostatectomy PSA; another lament with the refractory ED patient — these happen in numbers in every clinic, almost never move the needle toward better health outcomes, and compress the time available to those who need it, with their yellow-flag symptoms, new presentations, early treatment response assessment, or critical-period surveillance.

The corollary is a declaration that the *potential* for relevant clinical change, however improbable, is given at least the same weight as *actual* new, recent or evolving conditions. It's an enormous cost for the *opportunity* to identify a "what if" situation, assuming our radar and investigation choices are even up to the task. Think on the "number of needed visits" (NNV) to capture or prevent one critical development. Even for guideline-concordant care, this can be very high. Think of the five visits per patient recommended in the first 60 months after partial nephrectomy for low-risk RCC, while the recurrence rate for a low grade pT1a cancer is <2% over those five years.[2] Imagine the NNV after 10 years, or for catching some remediable development in that 6 mm lower pole stone, or re-scoping that LUTS patient for the fifth time. When we *do* uncover a sneaky development, our cognitive biases kick in to remind us what astute clinicians we are, and to solidify our practice of casting wide nets.

Slippery slope to nihilism and neglect, I see thee, but is a system built for maximum capture of long tail outcomes a model we'd endorse at a distance from our own practices? Does it respect clinical acumen or just a must-never-miss paranoia? As our waitlists bloat with consults that need our expertise, we tacitly endorse long-term 1:1 care for some over slightly less intensive care for most.

These are people after all though, right? Surely cold calculation of expected utility has no place in the forum of doctor-patient relationships and a person's health, right? Well, it turns out that we have plenty of experience here. Navigating and counselling around treatment tradeoffs, risk-stratifying and siloing, and especially screening, are places where we earn our hazard pay and do the thinking part of medicine to appropriately direct resources to maximize good and minimize harm, whether to patients or populations. What I'm describing is much the same — making calculated decisions about what is really likely to happen, and whether that merits a drawdown of dollars and time.

In case you haven't yet shattered your screen or shredded this page in CanMEDS-y indignation: what would this look like in practice? I'll suggest two principles: either a) don't see the patient at all; or b) change the venue of clinical interaction to increase efficiency, and maybe even efficacy and satisfaction.

Unnecessary in-person or virtual visits have several opportunities to die on the vine and incur fewer system costs. Referral and investigation pathways, like the excellent ones at Alberta Health Services' Pathway Hub, are a great example, and deserve routine adoption and expansion.[3] These afford primary care providers menus and checklists to cover most first-line management of urinary incontinence, prostate cancer screening and asymptomatic stones. The central site for accessing these pathways also provides consultation pathways for urgent urologic issues and highlights the role of e-consults for non-urgent advice. At the opposite end of the care spectrum is sunsetting of care when the value wanes. Stable and goal-congruent success in LUTS management, back-to-baseline-risk cancer surveillance or screening, accepting futility when it's clear. Space and time are limited, and your clinical skills are solid. Specialist care is highly valued by many patients, but parting is good medicine and public health when it's appropriate. Like the care pathways above, an articulated road map for ongoing monitoring or indications for repeat consultation can prevent bouncebacks and reassure patients and doctors.

But first, the manner of the bill. These are the easy-money visits that keep the mortgage paid! To this I say, "Oh," and refer a) back to the perspective of the system; and b) to the plenty-full hopper of "wait 1s" who need urologists, and whose care will be expedited. Simply decrease the amount of unnecessary care in your practice. There is plenty of incident urology out there.

Why not increase the spaces and modalities through which we provide care? Telemedicine had a stuttering start, then suddenly was realized over 36 hours in March 2020. Three-minute phone calls with near-zero patient inconvenience replaced thousands of days off, drives, and waits. I am an occasional e-consult provider in Ontario. My feedback report from referring clinicians says that 47% of the time "referral was originally contemplated but now avoided at this stage." These are common questions about UTI management, incidental imaging findings, single elevated PSA, and the like. Remuneration is based on time spent, and is less than a consult pays under OHIP, which is appropriate. More questions and care ought to funnel through these pathways, especially if they lead to resolution without referral.

For existing relationships, the next step — which may sound like your nightmare in the always-accessible, attention-addled world — would be a well-regulated messaging service. If a patient needs an investigation, but does not need the visit, why not a note from the urologist stating, "I've reviewed the scan, no changes, everything looking good; recommend repeating in 12 months; I'll send the requisition," or some such? Twenty seconds to write (and text expansion software, like dot phrases in the EMR, means you can dispense commonly used advice or links in stable, written form instead of ethereal words one hopes stick in the clinic), appropriate remuneration for the cognitive work and hazard of decision-making, and a green, "I'd like an in-person visit" button for those patients needing more. A bit less context, a few missed opportunities, but access to care for more people via time saved, in-clinic time freed for more fulsome patient encounters in meatspace. Good math to me, and what could possibly go wrong (rampant abuse by time-vampire hypochondriacs and mercenary doctors, as a start, but I ain't abiding counterpoints today ;)?

I don't think it's a stretch to say that there is abundant chaff to winnow in clinic. We have a resource problem in our systems for sure, but we have an allocation problem too, and that is a lever we can start pulling this week.

REFERENCES

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