

# Bucking the Medical Business

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Visit a typical primary care doctor - an internist or a family practitioner - these days, and this is what you are likely to get:

A short visit.

Nationwide, the mean length of a typical doctor's visit is 18.7 minutes, according to the National Center for Health Statistics. That means that half are longer, and half are shorter. Sometimes, much shorter.

A doctor racing through 20 to 30 patients a day, who may not be happy about it.

While most physicians, including primary care doctors, say they are satisfied with their jobs, more than 37 percent of the primary care doctors surveyed recently by Physicians Practice magazine and Merritt Hawkins, a nationwide physicians' recruiting firm, said they would not go into primary care if they had it to do all over again. And 28.6 percent said they would not practice medicine at all.

A staff of five to seven people per doctor in the front office to hassle with insurance payments and rescheduling.

More than 50 percent of a typical doctor's gross income goes up in smoke in overhead charges to deal mostly with insurance claims, according to the same survey.

And if you have Medicare, you're lucky to see a primary care doctor at all. Especially in Central Oregon.

Nationwide, the business of medicine is broken, especially for the primary care doctors who see the most patients, do the most cost-saving preventive care, and see the most elderly patients.

For patients, that means long waits for short appointments, resulting in advice that may not be followed because it's not properly understood.

For doctors, it means more work for dwindling incomes.

Some doctors are searching for radical solutions.

Dr. Michael Henderson, for example, is opting out. Of everything.

Henderson, a 34-year-old internist who opened his practice in Bend last month, won't take Medicare. He won't bill an insurance company or sign an insurance company's compensation contract, although he'll submit a claim for patients with private health insurance if they want to try to get reimbursed themselves.

Instead, it's a straightforward deal: For \$270, a new patient gets a full hour of Henderson's time - enough, in most cases, to do a full history and a thorough checkup, even for a senior citizen whose conversation might ramble a bit.

There's no waiting for an appointment. If necessary, he'll do home visits.

That, Henderson says, with considerable justification, is more than patients can get with most insurance-compensated doctors.

And Medicare patients are welcome. As long as they pay cash up front.

It may seem like Henderson has walked off the edge of the earth. But in a world where primary care physicians, in particular, are feeling whipsawed by declining Medicare and private insurance payments into seeing more and more patients at a faster and faster pace, just to stay afloat, Henderson thinks he's on firmer ground marketing his time directly to his patients.

He's not alone.

More than 300 doctors nationwide have opted to go to some kind of direct patient charging system, rather than hassling with Medicare and insurance claims, according to Dr. Garrison Bliss, a Seattle internist and a board member of the Society for Innovative Medical Practice Design, a nationwide organization dedicated to promoting physicians' flight from insurance payments and controls.

The numbers are still a microscopic portion of the nation's estimated 800,000 doctors, but they are growing "exponentially," Bliss said.

The reason: Primary care physicians are at the bottom of the compensation list for Medicare and for most private insurers, forcing many to see more patients than they can adequately treat. And the treatment itself is often influenced by what the insurance company will cover. Patients and doctors are increasingly dissatisfied, and the result is a primary care physician work force that is shrinking.

Or, as the American College of Physicians, an organization that represents 119,000 internists and medical students nationwide, put it in a January 2006 report, the practice of primary care medicine in the United States is facing an "impending collapse."

"Obviously, that's because it's a rotten way to work," Bliss said. "How many people do you know who would spend hundreds of thousands of dollars so they could spend three

years in graduate school, then two years in a low-paid residency, just so they could work in a sweatshop? Not even doctors are that stupid."

## **Shortages ahead**

The problems of the primary care field are not lost on medical school students. Between 1997 and 2005, the number of U.S. medical school graduates entering family practice residencies dropped 50 percent, according to the American Academy of Family Physicians.

Meanwhile, existing doctors are getting out.

Fifty percent of Oregon's doctors were 50 years old or older in 2004, the last year covered by the Oregon Medical Association's biennial Physicians Workforce Survey, and 20 percent of its primary care physicians planned to retire by 2009.

Oregon, in particular, may have a hard time replacing its retirees because the state's Medicare payment rates - set a decade ago to reflect the local medical costs that were prevalent at the time - are among the lowest in the nation, according to Paige Webster, director of communications for the Oregon Medical Association.

A doctor in Bend, for example, can expect to get \$50.08 for a standard office visit from an established Medicare patient. That's 26.4 percent less than a doctor in San Francisco would get for the same patient, 6.5 percent lower than Portland, and 11 percent lower than Seattle.

"We're really looking at an access to health care problem coming in the next few years," Webster said. "I mean, we are already seeing it to a certain extent, but the real crunch is coming our way."

In Central Oregon, the crunch is already here.

Stephanie Adams, marketing director for Whispering Winds Retirement, a relatively upscale assisted living center in Bend, hasn't been able to find a single local internist this summer who will accept new Medicare patients - a factor that has dissuaded some families from moving here, and has frustrated others in their attempts to move elderly parents closer to their children and grandchildren.

"I think it's naive for a place to say it's a draw for retirees, or should be a draw for retirees, if they can't find a primary care physician," Adams said. "It's just really unfortunate."

That particular problem may get worse before it gets better.

Medicare payments to doctors are scheduled to drop 5 percent next year, unless Congress acts to stop the cuts. If that happens, the state medical association's physician surveys indicate that more doctors will close their practices to Medicare patients, or at least limit access, exacerbating a situation that is already bad in outlying areas like Deschutes County.

Why would doctors block access to some of their neediest patients?

Economic survival. At the kind of Medicare rates paid in Oregon, a primary care doctor who fills the practice with Medicare patients is courting disaster.

Sandie McCreary, Henderson's lone office assistant, worked for one of the victims - a Prineville internist who closed his practice last year, leaving more than 1,000 patients to search for other doctors - a function, she said, of taking on too many low-paying Medicare patients.

"I have a lot of empathy and compassion for those who are on Medicare because, my gosh, what are they going to do?" McCreary said. "On the other hand, you've gotta keep the doors open."

"At least we're here for some. You can't save the world, I guess. Not and keep the doors open."

## **Crucial practice**

Primary care is a crucial and unique field of medicine.

Ideally, a primary care doctor is a master diagnostician, able to, say, determine that a woman's sudden waist-size expansion is due to ovarian cancer rather than overeating, or that a man's sudden problems with fatigue are caused by an odd medical malady, rather than by boredom on the job.

They are supposed to be masters of preventive medicine - the kind that can help people quit smoking, or lose weight, or cut down on diabetes-inducing habits - before minor problems or bad habits result in serious disorders that require expensive specialists.

And for older patients, or for anyone with chronic conditions like diabetes, high blood pressure or congestive heart failure, they are supposed to be the triage experts who can balance treatments for all of those conditions, or efficiently refer patients to specialists who can deal with the specific problems that arise in an illness's course.

A number of studies indicate that areas with a wealth of primary care doctors experience lower overall medical costs than areas dominated by specialists, mostly because expensive specialist care can be averted before it's needed if generalists have the time to head off disaster before it happens, according to an article published in the New England

Journal of Medicine last week by Dr. Thomas Bodenheimer, a University of California-San Francisco professor.

The problem with the way primary care medicine is practiced in the most common insurance-based practices today boils down to a common problem - time. Time that is driven by economics.

Doctors who get paid a thin amount per visit by Medicare and private insurers are motivated to squeeze an inordinate number of patient visits into every day, just to make ends meet, while providing some kind of income for themselves, Bodenheimer noted. Ninety-percent of patient-doctor visits last between six and 30 minutes, according to the National Center for Health Statistics.

But to adequately perform all the magic theoretically required of a primary care physician - particularly for the 60 million American patients who have multiple chronic health issues - takes more time.

It's estimated that a primary care doctor with 2,500 total patients, the national average, would have to spend 10.6 hours of work per day to deliver all the recommended care for patients who have multiple chronic-care issues, along with 7.4 hours to provide adequate preventive care, according to Bodenheimer.

Add in the 10 to 20 hours per week that the average doctor says must be spent on administrative duties, according to the OMA's physician survey, and you have an impossible situation for both patients and doctors.

One in which, "the majority of patients with diabetes, hypertension and other chronic conditions do not receive adequate clinical care, partly because half of all patients leave their office visits without having understood what the physicians want," Bodenheimer wrote.

## **Fixes?**

As the system is set up in American medicine today, insurers essentially dictate what they will pay for a vast array of pre-defined, pre-coded medical procedures.

The amounts paid, and even the definitions of the procedures, can vary widely among the hundreds of insurers that every insurance-accepting doctor's office needs to deal with. But the bottom line is pretty clear: If a doctor, like a surgeon, does something physical, they're paid more. If a doctor, like an internist, does something cerebral, like make a time-consuming diagnosis, they are paid less.

Generally, a lot less.

The median income for specialists of all types, such as a radiologist, a cardiologist or an anesthesiologist, was almost twice the pay of an average primary care physician in 2004, according to Bodenheimer, and the gap is widening.

Henderson, the new Bend internist, and Bliss, the Society for Innovative Medical Practice Design's spokesman, say they have their solution to that - return to the open marketplace, to let patients vote with their own dollars.

The theory: An insurance-free practice can slash staff and cut overhead since there are no insurance claims to process.

An insurance-free doctor can see fewer patients and spend more time with each, since the cost and time demand of running the office are greatly reduced.

The patients get more time with their doctors in exchange for paying cash out of their own pockets. There's less waiting for appointments, and more time for comprehensive medicine to be practiced .

There's a problem and a blessing contained in that idea.

Doctors can, indeed, run smaller practices with slower patient flows if they cut the overhead they would otherwise need to bill insurance - great for the patients who can afford their services. But cutting patient loads in an era of increasing physician scarcity may raise other problems.

Bliss said he slashed his practice by about a third of its former size, to about 800 patients, when he switched to monthly retainer payments 10 years ago. Each patient now pays \$95 a month for unlimited office visits and 24-hour coverage. About 10 percent of his patients are reduced-fee or no-fee.

One office staffer sets appointments for the three doctors in Bliss' practice. That's the sum total of the office staff.

Henderson said he attracted 14 new patients by Thursday, a few weeks after his newspaper and radio ads started running - ahead of his projections.

He hopes to cap his practice at about 900 patients, a little more than a third of the national average patient load.

As far as Bodenheimer is concerned, the trend toward pay-out-of-pocket, also known as "concierge" or "boutique" practices, is "misguided" from a social engineering standpoint.

"If the approach were widely adopted," he wrote, "the primary care work force would become grossly insufficient to care for the entire population."

On the other hand, in Henderson's estimation, the hope for his specialty may lie in his ability to profitably shrink his own patient base. The reasons, he said, lie in three key factors: job satisfaction for himself, consumer satisfaction for his patients, and stability.

Taking plenty of time with each patient was the way he was trained, Henderson said, and it's the way he intends to practice.

His rates are set at a level that would let him make an average living, and pay off his \$185,000 in medical school loans, along with the \$110,000 he has taken out in a line-of-credit loan so far to outfit his office and pay living expenses during the startup.

His wife, a nurse, also works to keep the financial wheels on at home - a modest house in northeast Bend where the couple lives with their two young children.

That plan will work and that lifestyle is sustainable, Henderson said, if his patients like his service well enough to pay him out of their own pockets to provide it.

If they do, they will have at least one doctor who is immune to cost-cutting in Medicare and in the private insurance industry, and Henderson figures more physicians might be attracted to the primary care field if his system works.

On the other hand, if he had gone into it in the standard way - by basing his practice on insurance payments - "if Medicare and private insurance companies drastically reduce my reimbursement, with my high debt load, I don't make it. I go bankrupt."

"Doing what I'm doing," Henderson said, "there's risk there. But in my estimation, it's less."

The private-pay approach, one of many variations known as consumer-driven health care, likely falls short of a solution to all the faults in the nation's insurance driven health care system, but not all insurers are opposed to innovations that will help "get the patient back in the driver's seat," said Pat Gibford, president and chief executive officer of Bend-based Clear Choice Health Plans.

More companies every year are opting to replace their full-service health insurance with Health Savings Accounts or other devices designed to handle lower-level medical bills, combined with high-deductible insurance policies designed to cover catastrophic care.

Putting money directly into the consumers' hands to shop for their own medical services could, in theory, result in better service and more efficiency across the board, Gibford said - if consumers can get enough information to comparison shop.

She doesn't think the information tools are there yet, but "if you have better-educated consumers, you can save dollars, you can lower your rates. I don't see us as on opposite sides."

Meanwhile, the doctors say they are saving money just by getting insurers out of their daily lives.

Henderson's medical practice consultant, Judy Bee of La Jolla, Calif., said his overhead savings have already been huge. Instead of spending \$25,000 to \$50,000 for a software package sophisticated enough to handle insurance coding for Medicare and hundreds of private insurers, he's gotten by nicely with a \$5,000 system to keep track of payments and scheduling.

"If it's going to work at all, it should work in Bend," Bee said. "Because there are people who go all the way to Portland for medical care, and that's just silly when you have a doctor who is right there, and perfectly well-trained, and you can reach him when you need him - that offers a lot."

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