My Continuing Recovery from Third-Party Medicine

Douglas J. Campbell, M.D.

Hello, my name is Doug, and I am a recovering third-party user.

Having realized my powerlessness over a system that has far more money and influence with consumers and political machines than I will ever strive to have, I began my recovery in 2006. When Medicare informed physicians of a scheduled across-the-board five percent pay cut in January 2007, I encouraged patients and joined in writing to Congress to redress this clear injustice to our noble profession.

I breathed a short sigh of relief when the politicians stayed the pay cut. But I immediately felt the wind knocked out of me again when they announced that this pay-cut freeze translated to a double pay cut of 10 percent in 2008. Since all the insurance contracts I had signed included reimbursement rates linked to Medicare, I finally saw the light. This system will not get better.

This was only the proverbial last straw for me. For years I felt great frustration as I tried to provide quality medicine to patients while negotiating third-party interference, especially with Medicare and Medicaid. Two examples:

The first involved a white man in his 40s on disability because of chronic low-back pain and fibromyalgia. Using appropriate doses of antidepressants, anticonvulsants, and Oxycontin, I found a stable dose in a few months that enabled him to play piano twice a week as a volunteer for the choir at a junior high school—far more than he had been able to do for years. Without warning, because of a media report of high rates of Oxycontin abuse, this patient's Medicaid carrier unilaterally decided it would no longer cover any prescriptions for Oxycontin except for cancer pain or hospice. Despite the fact that we had already tried other opioids for this patient, it took me six months to jump through the bureaucratic hoops that allowed me to restore this patient to the same medications, but the next year they threatened to put him through the painful process again.

When I graduated from medical school, I took an oath to do no harm. I could see that if I continued to provide medical care to patients under this kind of system, I would be forced to continually compromise that oath each time a similar situation developed, so I dropped that Medicaid provider.

The second example came later, in 2008. After I dropped most of my third-party contracts, I maintained a panel of about 25 legitimate Medicaid patients with whom I had a long-term relationship, and to whom I felt a moral obligation to continue to help. When in 2008 this Medicaid provider decided to pull out entirely in my county, I declined to sign a contract with the new provider, but inquired that if I were willing to provide my services pro bono to these 25 patients, would they still honor my prescriptions and referrals? I have to believe that control, not compassion, was the ultimate goal when their answer was an unequivocal "No."

Making the Transition

In 2007, armed with tapes, handouts, and numerous references from AAPS, I explained my feelings to the two other physicians with whom I share office space and employees. Obviously it would have been easier for our staff if all of us used the same practice model, but although we share overhead, we are not a partnership. I had already become nonparticipating in Medicare as of Jan 1, 2007, with the intention to opt out sometime later that year. I informed them of my decision to develop a third-party-free practice. I shared with them my research and expressed the hope that they would join me in this model, although I was careful to not insist because I didn't feel I could force my decision upon them.

Initially, both physicians were excited about making the transition, but within a few months, and for independent reasons, they backed out. One of them decided to quit family practice altogether and become a director of hospice and nursing-home care. The other had started doing a substantial amount of allergy desensitization treatments, and felt that he would lose too much of this business if provided only on a cash basis. Nevertheless, as an association of physician corporations, we then dropped all but a handful of our insurance contracts, based on two factors—how much hassle we and our staff experienced with the company, and how well we were reimbursed. I used as much word of mouth as possible in our tri-city area of about 150,000 to encourage patients without insurance, or those with health savings accounts, to come my way.

With the announcements up and the gossip mill grinding, I dropped all the rest of the insurance panels except for Blue Cross Blue Shield as of Dec 31, 2007. I kept BCBS because I was nervous about being able to safely make the transition and still cover my share of the overhead.

The only other exceptions to a third-party-free practice were about 25 patients on regular Medicaid (as mentioned above), and six or seven who were on the county's long-term care program. I

maintained these panels because I felt a certain moral obligation to these patients, although my feelings about any obligation to society in general have changed, since choosing to care for such patients without compensation (and therefore no contract with the state) is apparently not an option.

Early in 2007, our local paper, fortuitously, did a series of articles about access to health care, and interviewed me about it. They quoted me accurately. Public reaction was strongly supportive of the points I made, and indeed, as a result I have had several Medicare-eligible patients come to establish care with me. In each case they cited what they saw as a positive stand for honesty and principle.

The Financial Impact

The impact of dropping most of my third-party panels has been enormous. In the first quarter of 2008, I saw my income drop by about half. The majority of those who had insurance with which I no longer contract went elsewhere, although some individuals have been remarkably loyal. Most of my Medicare patients also left, but in our area there is a definite shortage of primary-care physicians, and the median age is considerably skewed toward retirement age because Prescott, Ariz., was listed as the top place to retire in a national magazine a few years ago.

Partly because of the shortage, and I dare say because of the quality of care I provide, many Medicare patients have already returned to my practice, and I anticipate more. Since the first quarter of the year, my income has steadily climbed, and I am seeing a lot of new patients, not only those with BCBS, but also those without insurance, and those with private insurance that they submit themselves. I also do not know how much of my decreased income is the result of the overall downturn in the American economy. I charge $200/hour, usually in 15- or 30-minute slots, so $50 for a typical appointment and $100 for a physical, and I adjust my fee if I know my patients cannot pay that amount.

I am constantly seeing referrals from the emergency room, from other doctors, from pharmacists, and from the patients I already have. The frustration and stress from third-party payers have decreased greatly. I feel better about what I do. I work for my patients, and they know it.

It is delightful to see the reaction of a patient, after I have frozen 25 or 30 actinic keratoses, when I tell him what the standard charges are for the procedure, and then what I am going to charge. I know that I have not only done a service, but I have a loyal patient. I don't charge for e-mails or phone calls. I return phone calls the day I get the message, but I remind patients that e-mails are for non-urgent messages. "Do NOT e-mail me telling me that you are having chest pain!"

I have not made the transition to drop BCBS yet, although I still anticipate doing so. There have been many other changes in the last few years in my practice that make me want to wait a while, including the loss of one physician assistant, and recruiting a couple of other physicians, as well as the economic downturn. My long-term associate and I are purchasing the building together, and running the business as co-owners, so I cannot anticipate my overhead dropping as much as it would if all of us were completely third party free, or if I went solo. Having practiced solo in the past, I much prefer having a colleague under the same roof.

Electronic Medical Records

For us, there are also the costs associated with electronic medical records. When two other physicians and I first created Oaklawn Family Practice in 2000, we made the decision to start from the beginning with electronic medical records. There are some open-source products available now that I would definitely recommend over the program we use, and although there is no doubt that the cost was excessive in the beginning, I love EMRs. We never lose a chart, nor do we have to employ anyone to track charts or update and purge our stacks. There is the advantage of being able to access charts from home using a secure Internet connection. Laboratory results can easily be tracked and graphed, and even e-mails are easily cut-and-pasted into the chart.

Each exam room has a computer mounted on a platform that pivots out from the wall. I can touch-type about 90 wpm, and by positioning the computer screen between myself and the patient, I maintain eye contact while I take the history, create my SOAP note, give nursing staff orders, or even answer intra-office messages and write work excuses or short letters—all while I am with the patient.

Templates remind me of what I want to track in health maintenance exams and automatically fill in a lot of the review material like family history, social history, and past medical history. When I am done seeing the patient, I am therefore also done with my note. Sometimes I may even access the Internet with the patient to show them a resource, or get them specific information such as the latest recommendations for malaria prophylaxis for Ghana or New Delhi from the Centers for Disease Control and Prevention (CDC).

My experience with EMRs makes me never want to go back to a paper record. I do recognize, however, that the initial expense is greater. It is also important to choose a program that will not allow access to one's records by a third party.

Conclusions

I now believe more than ever that third-party-free medicine is better medicine both for patients and physicians, and has the hope of being sustainable. I also find it fascinating to note that as soon as patients have to accept the financial consequences of their choices when it comes to prevention, cost of treatment, or even the cost of diagnosis, they immediately exercise a level of restraint and stewardship that is sadly lacking when a third party is involved.

If our politicians really want to see that everyone has access to quality medical care, it is time that they pay attention to human nature.

Douglas J. Campbell, M.D., practices family medicine. Address: 1672