

Independent Personal Medical Care

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After several discussions with AAPS staff, I was persuaded to overcome my shyness and write about the practice I have created over the past three years.

The terms “conciierge” and “boutique” medicine come to mind, but this would be calling a bagel a doughnut. They look rather the same, but taste entirely different. I’m Jewish with a fondness for lox, cream cheese, onion, and tomato on my bagels. Try that with a doughnut!

I am a board-certified, Midwestern-trained family physician. I spent three years in the U.S. Public Health Service in rural Alabama, where I was assigned after requesting to be sent to upstate New York. The government’s plan was to place primary-care doctors in communities where they might be happy and stay. In my case, they sent a skiing, winter-loving New England Jew to upstate Alabama, a mere taste of the idiocratic business to come. The people in Alabama, of course, were wonderful. I married one of them.

Escaping from the HMO

I moved back to New England in July 1987, just as the HMOs were flourishing. I took over the practice of a retiring general practitioner and within a few years had more than 3,000 patients. Initially, we received management fees from the HMOs and were treated rather well. Thinking that I was doing my patients a favor, it was my policy at that time to accept all insurers.

The idiocracy grew exponentially, with Medicare leading the way. By the mid-1990s I was buried in ridiculous paperwork and regulations that prevented me from caring for my patients appropriately. To cover the cost of the idiocracy, I had to see far more patients per day than I was capable of handling in a way I considered satisfactory. My professional satisfaction and income were dropping fast. I was within millimeters of quitting the profession.

Then one day I ran the numbers. For me to take home \$50, someone somewhere had to spend \$200.

I’m a cyclist. I ride more than 4,000 miles yearly. Cyclists spend much of their wheel time within themselves. Joggers call it “spacing.” During one of these rides it occurred to me that if I dumped all my insurance and Medicare contracts, my overhead would fall by approximately \$300,000 per year! I could take much more comprehensive care of a smaller patient population and avoid the severe conflicts of interest in accepting money from third-party payers.

Furthermore, if I operated on a retainer model I could further minimize bureaucracy and keep overhead and prices even lower. The real shock came when I started applying modern technology to the new practice, further doubling my efficiency. The other benefit of the retainer model in primary care is that it removes the financial incentive from individual services provided. Patients have the reassurance that services provided by me are purely for their benefit, as opposed to the benefit of my pocketbook.

So, in 2003 I sold my old practice to a local hospital, which hired a new physician to take over. Part of the deal was that I would be allowed to market to a specific 500 patients, of whom 200 came along with me immediately.

Our Practice Model

I set up a brand new practice, buying the best equipment modern technology had to offer, and I based the record-keeping system on electronic medical records (EMRs) utilizing the Soapware program. We have a separate scheduling program called Schedule View and a program that prints out claims forms

Financial aspects of the practice are run from home with a Quickbooks program. We bill by quarterly statements, or by monthly or quarterly automatic credit-card debit. Our elderly patients often pay us for the full year in advance, usually in cash. My belief is that this is a ritual they bring with them from the old days when patients handed their doctor whatever they could afford in cash on the way out the door.

I do not take any money from third-party payers. I do not transmit anyone’s private medical information anywhere. My office is HIPAA non-covered under the “country doctor” exemption established by AAPS lawsuit. I do not have or need an NPI. The government clearly is in strong pursuit of the private confidential data our patients entrust to us, and it is up to physicians to protect it. No one is holding a gun to our heads and forcing us to divulge our patients’ private confidential information, or to abdicate our clinical decision-making.

EMRs have been vilified as a tool to be used by the government and insurance companies for data-mining purposes, so as to control the practice of medicine. In fact, this will occur if physicians are complicit in this initiative to destroy patient privacy. However, data that is not transmitted outside your practice remains private and confidential.

Data isolation is easy to achieve. Simply refuse to deal with any third-party payers, and keep your computers off the Internet.

EMRs are extremely valuable in a practice like mine. They can be scanned more than 10 times as fast as a paper chart, and the information is far more legible. There is no pulling and filing of charts.

Most lab work is installed directly into the patient’s chart through a quadruple-firewalled system. Soapware automatically notifies us when new data has been added to a patient’s chart. Data is not more accurate just because it is electronic (garbage in still means garbage out); careful attention to accurate data input is essential.

Although I am third party free, we do help our insured patients collect money from their insurance companies. We generate the appropriate claims forms with the customary codes, and charge for the given service. Patients mail claim forms to their insurers and collect whatever the insurer allows. Many families recover most of the retainer in this manner.

Our fee for most adults is \$250 per quarter. For people with catastrophic insurance, or none, we charge \$375 per quarter, but we then also cover all blood work drawn in my office, all recommended screening tests, and plain X-rays performed by a local radiology group. Dependent children under age 21 are treated free.

The only type of “insurance” that creates problems is the HMO that requires all referrals to come from an “in network” physician. Fortunately, I am able to assist these patients in receiving appropriate reimbursement by having a local HMO doctor see them

and make an appropriate referral. There are never additional copayments or charges. Occasionally an established patient will bring in a family member, usually a parent, for a consult on a problem that they don't think is being handled well. We have a \$100 flat charge for that service. If the patient decides to join the practice, the charge is deducted from the first-quarter payment.

Medicare patients pay \$250 per quarter, but since I am opted out of Medicare, there are no 20 percent copayments, and all services such as their physicals and cosmetic work are covered by the retainer. Because I am available at all times, unnecessary trips to the ER and hospitalizations are prevented. As a result, many of my elderly patients have less out-of-pocket expense than they would have seeing a fee-for-service Medicare doctor.

The real benefit of this practice model, however, is the improvement in the quality of medical care I am able to provide to my patients. There are only two people working in my practice, my wife and I—just like in the old days. Our office facility basically consists of three rooms. The reception room looks more like a living room, complete with a high-definition plasma TV—there's nothing like *Shrek* to entertain the youngsters. The entire office is an art gallery with pieces for sale by the individual artists.

My office is 14-by-14 feet. It has a double-sided desk with computer monitors facing both sides. On the patient side are two parlor chairs. The patients' monitor has two inputs so they can switch to a separate computer that does Internet duty. None of the medical computers are ever used to access the Internet.

The patient always sees whatever I am doing. *UpToDate*, a medical encyclopedia that is updated quarterly, is loaded so patients and I can research topics in real time. Netter's encyclopedia is also loaded. Ever try to explain to someone what a mitral valve looks like? Everything else that we use, such as the U.S. Preventative Services Task Force, is available online.

The shortest appointment we schedule is 30 minutes. We always leave two one-hour slots in the day for call-ins. I have much more time to spend with my patients, and their level of confidence in my judgment and their satisfaction is much higher than the norm. The attrition rate in my practice last year was 0.75 percent. One patient moved out of town, and the other died at age 89. Compare that to the 10 percent rate in internal medicine practices, and the 20 percent rate in pediatric practices.

I have a single 16-by-16-foot surgery/examination room with an overhead surgical light; a complete Midmark diagnostics system with electrocardiogram, Holter monitoring, and spirometry capability; a low-level Ritter electric examination table with a foot switch; a full crash cart with an automatic external defibrillator (AED); a computerized Ritter sterilizer; Heine fiberoptic surgical loops, a ConMed Hyfrecator 2000, and a fine complement of German surgical instruments. I plan to purchase a video flexible sigmoidoscope soon. The cost of setting up this office including all equipment, furniture, computers, printers, and programming was less than \$50,000.

I am available to my patients at all times except when I am out of town for continuing medical education or vacation. My patients have my cell phone number, and that privilege has not yet been abused. To the contrary, I usually have to reprimand patients for not calling me when they should—for example, a woman who fell and fractured her right distal fibula on New Year's Day finally decided to call me two weeks later. After-hours and weekend injuries and illnesses are either seen in the office or by house call. With the 300 patients we now have, I might have to make one house call per month and less than one weekend trip to the office monthly. But, when I come, I'm seen as a hero. Serving patients in this manner is the reason most of us went to medical school in the first place.

Answering Our Critics

Over the past three years I have had to field many derogatory comments, from colleagues and others, about my practice model. First among criticisms is that I practice "concierge" or "boutique" medicine and, in the view of critics, concentrate on extracting money from the wealthy for the privilege. However, I only have three patients that anyone would consider wealthy. Most of my patients are middle-class, 30 percent are elderly, and two are on Medicaid. The only common denominator is that they all abhor the current medical system and are looking for better, more personal care.

Another criticism is that if more doctors switch to my model of practice, we will develop an acute shortage of primary-care doctors. But consider the data. Primary-care doctors are already quitting or retiring early, and enrollment in primary-care residencies is plummeting. Care delivered by third-party medicine is in general inefficient, overly defensive, extremely overpriced, lacking in continuity, and hopelessly impersonal even if friendly. Renaming a medical clinic by calling it a "Medical Home" will not solve the problem.

The advantage of practices like mine is that we have far better relationships with our patients, and have more time to deal with all of the issues that concern them. Therefore, we tend to be far less defensive and more thoughtful in our practice. Patient drift to higher-cost specialists is much lower. The result is better care at lower cost, plus far greater professional satisfaction, which could encourage more bright young doctors to enter the field of primary care.

Socialist critics' favorite objection is that "most of my patients can't afford the \$250 per quarter." Yet many of these same people often spend more than that on cigarettes and beer. Beer is in the budget; providing for their medical care often is not. In the United States, however, we make both Chevrolets and Cadillacs. The government cannot tell Cadillac manufacturers that they must stop making cars just because some people cannot or do not choose to pay the price. In the end, it is a personal value judgment that no one else, including our government, has the right to interfere with. And, I am proud to say that in the medical industry, I make Cadillacs.

Insurance Is Not for Primary Care

Medical insurance to cover primary care makes no sense. People do not buy insurance to paint their house. If they did, the result would be cheap paint, cheaper labor, a rush job, and in the end, a job that cost three times more than it should. In other words, the cost-to-benefit ratio for such insurance is very poor. Insurance is for protecting your financial assets in the unlikely event that your house burns down. Here, the cost-to-benefit ratio makes sense. The potential benefit to the subscriber is huge, but the cost to the insurance company (and hence the premium) is low. Obviously, the likelihood of a fire is far less than the need for a paint job every three to five years.

The medical insurance industry bureaucracy is an idiocracy. Imposing it on primary care leads to decreased access, higher costs, more defensive medicine, and overuse of specialists.

Primary-care clinics without the idiocratic load of the insurance companies can provide very affordable care. The consumer should decide whether he wants "luxury" care or not. Various models are available. People should consider using a Health Savings Account to cover primary-care expenses, with the added advantage of building retirement savings—and protection from the impending implosion of Medicare.

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