Joint Economic Committee of Congress

Testimony of

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April 28, 2004

Good morning. Thank you for inviting me to speak with you today.

My name is Dr. Robert Berry. I graduated from the University of North Carolina Medical School in 1989 and did my residency in Primary Care Internal Medicine at the University of Alabama Hospitals in Birmingham. I became board certified in Internal Medicine in 1992, scoring at the 99th percentile on the exam's "core component" – a measure of competency in General Internal Medicine. Up until I started this clinic over three years ago, I practiced Internal Medicine for six months and Emergency Medicine for the balance. I became boarded in Emergency Medicine in 2003.

I represent a growing movement in cash only practices and the patients who use them. Yet our clinic is a little different in that we center medical services around the unique needs of the uninsured. They are the most cost effective healthcare consumers, and we all could learn something from them.

Our clinic is similar to charity clinics in that it serves patients falling through the cracks of our broken healthcare system - except we don't receive any taxpayers' funds either directly as subsidies or indirectly as a tax-exempt 501c3 corporation. It is similar to boutique clinics in that it contracts directly with its patients - except that most of our patients don't have insurance.

How and why I started an insurance-free medical clinic

In January 2001 I left ER medicine to start a clinic primarily for the uninsured of my community as an attempt to flesh out in my own life an answer to the age-old question, "Who is my neighbor?" Of course, I don't refuse other patients willing to do "**P**ayment **A**t **T**he **M**oment **O**f **S**ervice." In fact, because this seemed to be the unifying theme of our practice, I chose its acronym PATMOS as the name for the clinic.

As an ER physician, I knew the people the charts classified as "self-pays." In a small community such as ours, I purchase goods and services from many of them. They are all in a real sense my neighbors – too poor for $10 co-pay insurance and too rich for Medicaid. Like the political prisoners Rome used to banish to Patmos Island, they are effectively political exiles within our healthcare system.

Most doctors refuse to see them. In fact, one of our uninsured patients mentioned at the beginning of a front and center article in the Wall Street Journal last November that he had been refused care by every primary care doctor he called in a nearby town before coming to us. For practices set up for insurance, the uninsured tend to disrupt patient flow. Many cannot pay for tests and procedures sometimes needed to exclude potentially litigable misdiagnoses. The uninsured simply take too much time with too much risk for uncertain payment. No wonder physicians turn them away and refer them to the ER.

But the ER, as we all know, isn't an appropriate place for these patients either. Charges are higher, work-ups much more expensive, and few physicians are willing to see them in follow-up. Although one Princeton healthcare expert referred to them in *Newsweek* as "expendable people – mostly low-income, hard-working stiffs, socially and politically marginal," I had learned from my work in the ER that they are neither destitute nor derelict. In our community they are farmers, construction workers, stone masons, Hispanics, Mennonite families, beauticians, cleaning ladies, small business owners and their employees – hard working folk who pay their bills. They told me they didn't have the time to wait at government clinics and did not like the quality of care they received there.

They urged me to start a practice and promised that they would come see me if I did. I thought that maybe over time this clinic might replace my income from the ER with the hope that I could jettison increasingly wasteful, irrational, and dehumanizing bureaucracies as much as possible from my practice and from my life.

Because of the charitable nature of the clinic, I had considered making it a non-profit to take advantage of tax breaks and to raise money for my own salary. After several discussions with my attorney, I had pretty much decided against it. He pointed out that dealing with a board would probably be about as frustrating as every other bureaucracy I had encountered since my residency. In addition, even though I would be the one building the patient base, the board could dismiss me whenever it wished, and the years I would have invested might well end in futility and bitterness. Since the sick and injured we will always have with us, I reasoned that it was more prudent in the long run to depend on them for my income rather than on fickle donors and ever-changing tax laws. The long-term risks did not appear to be worth the short-term financial security a non-profit might offer.

The idea of making the clinic non-profit became academic very quickly as my plans to make the clinic full time were realized sooner than I had expected. For various reasons, the president of the hospital where I worked had my ER contract terminated abruptly. I simply did not have time to start a practice and raise money too. Had I pursued the non-profit option, the idea of this clinic might still be in committee. At that point, I had to make a decision – either obtain ER work at another hospital or start the clinic full time. For better or worse I stepped out in faith and decided on the latter. The clinic was up and running within two weeks of my dismissal.

A visit to the clinic

In general we are a walk-in clinic for routine minor illnesses and injuries – I would characterize us as a high capability urgent care. We are open every morning Monday through Saturday for walk-ins and some afternoons by

appointment. Sometimes I treat established patients over the phone and charge their credit card.

So let's suppose that you are a patient coming to the clinic for the first time – what would you see and experience?

As you walk up to the clinic, you will see a large sign that has information about the cost for various medical problems. Poison ivy - $25. Sore throat - $35. Simple lacerations - $95. A doctor who actually enjoys practicing medicine today – priceless (and we do take Mastercard). These fees, which are about 50% of the Medicare Allowable, are listed on the brochure I brought with me and should be available to you.

The only way that I can keep my prices so low is by avoiding the crushing overhead and hassles that other physicians allow third party payers to impose on their practices. I even don't take Medicare, a potential source of a great number of patients, because doing so would force the uninsured to pay for the cost of processing other patients' medical claims – a service from which they clearly do not benefit. Forcing me to hire more staff to bill on behalf of Medicare beneficiaries would defeat the purpose of my clinic. From day one, the clinic has centered care around the uninsured and patients with high deductibles, even if it meant seeing fewer patients and thus receiving a lower income.

Contracting with a third party payer obligates a physician to some extent to the one paying the bills. This would force me into a conflict of interest I am not willing to accept. I recoil at the thought of being anything less than completely transparent, putting before each patient my best recommendations and their estimated costs. This is exactly how I would like to be treated if I were in their shoes. This engenders a trust not currently present when a bureaucrat is allowed to intrude into the doctor-patient relationship – one that many Americans today still consider second in importance only to family.

Advertising my fees and qualifications, by the way, initially ran counter to my ideas of medical professionalism. I realized I had to overcome this professional arrogance if my core clientele – the uninsured and people with high

deductibles – were to learn about the cost breaks of a clinic not taking insurance. Such advertising is permitted within the by-laws of our state medical board.

We have worked out discounts with various other providers in the area so that a cholesterol panel is $20 to the patient; a complete chemistry is $25; X-ray's with a radiologist's interpretation at Takoma Adventist Hospital are $70. Some patients choose to pay one of the chiropractors near the clinic $35 for an extremity X-ray and bring the film back to me for an interpretation and treatment. Costs to the patient here are about 60% those of other physicians' offices, 40% of the local urgent care, and 10 to 20% of the local ER's.

Upon entering the clinic, you see to your immediate right my board certification diplomas in Internal Medicine and Emergency Medicine, my Internal Medicine residency certificate from the University of Alabama Hospitals, my medical school diploma, and state license. You decide, perhaps, that I'm not some sort of quack after all and proceed to sign in at the desk where my fee schedule is posted. Everything is up front and honest.

My office assistant realizes that you have not been here before. She offers you a patient information sheet that usually takes less than 5 minutes to fill out. Since we fit under the Country Doctor exemption, there are no long HIPAA confidentiality agreements to pore over and sign. In fact, I have had some insured patients who have transferred their care to my clinic because they refused to sign these incomprehensible forms at their former physician's office.

The intake sheet explains a little about our clinic – that we don't take insurance and expect payment at the time of service. It also says that if you do have commercial insurance we can forward the claim to a billing service for a $10 surcharge, but there is no guarantee that you will be reimbursed.

Since the majority of our patients don't have insurance, they are delighted to learn about our service. Some bemoan that they had wished they had known about us before they incurred their $1000 bill at the ER. It is personally very gratifying to be appreciated by the lower middle class folk who form the economic backbone of this country and whom I have the privilege of calling my friends and neighbors.

Being in this type of practice gives me, I believe, a unique perspective on the mindset of Americans who are used to low co-pay, low deductible insurance. Every day presents me with new lessons in human behavior. It can be quite amusing, for example, to observe their responses to my intake sheet – they're kind of like Pavlov's dogs – except rather than salivating in anticipation of a delicious meal they are conditioned to expect healthcare on the cheap (if not entirely free). You can see the wheels churning as they try to process this new thing confronting them.

For example, after reading our intake sheet one Sunday afternoon, one very wealthy, prominent member of our community developed a puzzled look and in all sincerity asked me if my clinic were legal. I responded, "For now, but if we adopt single payer healthcare like Canada's, it won't. Then you will have to wait in the ER all afternoon."

Others have walked out in disgust announcing to everyone in the waiting room that they were off to see a real doctor. One teenage boy ran into the clinic to ask how much it would cost to treat him for a sore throat. "Thirty-five dollars," my assistant replied. He ran back to the front seat passenger side of his family's Lexus and informed his mother. She shook her head in disgust and peeled off.

With some it seems I'm the last stop in their desperate attempt to find a doctor without having to resort to the ER. After trying their regular doctor (2 weeks for the next appointment - sorry), and the local urgent care where waits can be on the order of hours not minutes, they rush in here delighted to find they will be seen quickly. Their countenance changes when they find out we don't take third party payment.

They can be heard agonizing, "But I have good insurance – just a $10 co-pay - see it says so right here on my card." I examine the card and, well, the information on it is all very interesting but I have to tell them that it has no currency at our clinic. I simply state the obvious - that health insurance does not equal health care (as many patients are quickly coming to realize).

Sometimes I'll press the point and ask if they have insurance for routine car maintenance to which, of course, they reply no. Then I ask, "If you don't

have insurance for routine car maintenance, they why have it for routine medical care since fees at our clinic run anywhere between an oil change and a brake job." A lot of time this comparison gets through to them. If still not convinced, I just tell them they have a decision to make about the value of their time and health.

It's obvious that we have a lot of re-educating to do of the commercially insured population. But mark my word, as their co-pays and deductibles are increasing, you wouldn't believe how quickly they are learning. One company just raised its co-pay to $35, and I am seeing many more of its employees at the clinic. Price when not adulterated by government subsidies can be a wonderful educator of value.

Getting back to the patient: While you are filling out your intake sheet you happen to overhear typical conversations my office assistant has with people calling on the phone. "No, we don't take insurance. The average fee is between $35 and $50." It seems if they were so discriminating when it came to spending their insurer's money, we wouldn't have a healthcare crisis on our hands.

Anyway, you filled out your sheet and are brought back by my office assistant to an exam room. She serves as a combination receptionist / lab tech / and nursing assistant. She takes your vitals and pulse ox with one of those machines you see in ER's while jotting down your chief complaint. She carries the phone with her, and if it rings will answer, "Can you hold, please?" until she finishes with the patient, or if she's real busy I will take the call. The patients in the clinic get first priority. When the clinic is busy, I will take the vital signs myself with the machine and usually by the time it has finished I have pretty well completed the history as well.

Let's say you have the stomach bug of the month, and I determine you aren't dehydrated and are able to keep pills down. I dispense 12 Promethazine 25mg pills prepackaged from our little dispensary for your nausea so you don't have to stop by a pharmacy on the way home. I show you the instructions on the label, write them on the discharge instructions, and give you our handout sheet on clear liquid diets, and you are out the door for $40.

If you are dehydrated, I'll recommend an IV, and if you agree, I will administer 2 liters of IV fluids over about an hour, give Promethazine IV if you have a driver, and before you leave dispense Promethazine gel with instructions about how to apply it on the inside of your forearm. You go from feeling like a withered plant to bursting with life again – all for only $130. In the ER this can run over $1,000.

Do the prices seem a little low to you? They probably are. However, I would much prefer a modest income and the freedom to take care of appreciative patients than being rich and forced by government mandate to take care of patients who feel they are somehow entitled to my services.

Clinic Results

PATMOS is located in a village of 16,000, in a county of 60,000, in a state where only 10% are without insurance (one of the least in the nation) and 25% have Medicaid (one of the highest in the nation). In addition, there is a government run clinic in town, two others within 15 miles of town, and a charity clinic in a town 25 miles away. No large company in our community to my knowledge has yet to adopt a consumer driven health plan such as an HRA or an HSA where employees are motivated to find low-cost healthcare. I compete daily against 10 to 20 dollar co-pays.

Given a market so stacked against us, how have we been able to survive these last three years? By providing value and service at fair and honest prices as any other successful small business does. We have nearly 5000 patient charts with (at last count) approximately 51% uninsured, 38% commercially insured, 8% Medicaid recipients, and 3% percent Medicare. The clinic has added 800 new patients in the last six months.

My break-even volume is about 1.2 patients an hour. My average volume over the last 6 months has been about 3 patients an hour, which makes my net income before taxes a little less than what I was making in the local ER. At 4 patients an hour, I would be making about 50% more than I was making in the

ER. The average cost per visit over the last six months including the professional fee, tests, and medicines has been $51.53 per patient.

To put this in more concrete terms, an uninsured patient came to us last week from the local urgent care after refusing to pay the $105 they required up front to be seen for a sore throat. She paid us $35 after the visit.

Other PATMOS-type clinics

I am not alone in this effort. There are many other physicians in this country currently doing low-cost, non-boutique cash-only clinics, and they are gaining increasing media exposure. They are filling real needs in this country, especially for the uninsured.

The largest such network of clinics is SimpleCare, founded in 1998 by two family physicians in Seattle, WA. According to Vern Cherewatenko, MD, there are now over 2000 healthcare providers who are members of their organization (including me). They started their cash only clinic out of financial necessity. Their managed care market was squeezing them so severely by increasing overhead and hassles while cutting their reimbursement that they actually began losing money.

They had five clinics in an IPA and were billing $10 million per year, but were losing $80,000 per month, despite doing everything to cut expenses to the bone. Their average reimbursement per patient visit was $43 while the average cost per patient visit was $50 ($20 of which was incurred in billing). The overhead was so bad that he remarks, "At one time we needed six medical records clerks…just to photocopy the records of patients who, on a monthly basis, transferred in and out of our care on these various managed care plans."

Dr. Cherewatenko is the most prominent leader in the direct payment movement. He appeared on the cover of the April 2002 issue of U.S News & World Report, on NBC news and PBS, as well as in the Wall Street Journal, USA Today, and Forbes Magazine. On April 4th, his organization received national exposure through the AP News service, which was then picked up by CNN and many local media throughout the country. Within three days, his website had

over 25,000 hits with the average time per hit being over 40 minutes. He had interviews taped last week with both the NBC Nightly News and CNN Financial News.

The co-founder of SimpleCare, David MacDonald, D.O, has gone on to start Liberty Health Group, "a medical consulting company with a special focus on the Consumer Directed Health Care Model."

California family physician Tom Lagrelius helped start INDOC – Independent Doctors of the South Bay – in 1997 and is currently listed among its directors. It "was created and serves as a nonprofit patient-oriented doctor referral network that is committed to advancing personalize, private, 'unmanaged' healthcare." The INDOC website contends that "third-party interference between patient and doctor should have no place in the practice of medicine."

CashCare America in Warrenton, VA "is building a nationwide network of physicians, dentists, pharmacies, and hospitals that have pledged to charge you the discounted rate offered to managed care insurance companies if you pay cash rather than rely on insurance reimbursement."

Several religious medical cost sharing plans offer a non-insurance alternative where members share expenses to a large deductible and the risk is reinsured beyond that. Amounts of the monthly "share" tend to run a fraction of the cost of most health insurance premiums. Brochures for two such plans, Samaritan Ministries and Medi-Share, are available in our clinic's waiting room.

Todd Coulter, MD, a black internist from Mississippi, has had a cash only practice for 2 years. He charges a flat rate of $40 per visit. Head of the AMA's young members section, he advises other physicians to "get off the Medicare plantation." His clinic has been featured on the CBS Evening News.

Mike Harris, MD, a urologist from Michigan, got rid of all his third party contracts several years ago. Herb Rubin, a gastroenterologist from California, has been doing direct payment for a number of years and decries "the coarsening and commoditization of our once noble profession" at the hands of managed care. Curtis Harris, M.D., J.D., an endocrinologist from Oklahoma, started doing cash only about 5 years ago. He is on the board of the Christian Medical & Dental

Association and recently submitted an article concerning cash only clinics to be printed in the next issue of the CMDA magazine *Today's Christian Doctor*. Lawrence Huntoon, MD, a neurologist from New York, just recently gave up his last insurance contract as a non-participating provider with Medicare.

The week after I gave a talk to a medical organization last fall, an attendee called me to say he had decided to drop all insurance contracts and start a cash-only practice. The April 23rd issue of Medical Economics contained an article entitled, "No coding, no insurers – no kidding," featuring not only SimpleCare but many other physicians throughout the country whom I had never heard of starting cash only practices on their own just as I have.

It appears that we are tapping into a wellspring of patient and physician dissatisfaction with costly, inefficient, paternalistic, and impersonal bureaucratic medicine. People today want control over their non-catastrophic medical care – and they want it right now, from someone they trust, and at fair and honest prices. With the advent of consumer-driven health plans empowering Americans with pre-tax, tax-deferred savings accounts to spend at clinics like these, we are poised, I believe, to see a grassroots revolution in the delivery of routine medical care.

Over a year ago, Tennessee Representative Zach Wamp in an editorial entitled "Is Healthcare Facing a 'Perfect Storm'?" identified many factors converging together threatening to sink our healthcare system. He warned us then that a federal government takeover of medicine might be imminent. It appears now that consumer-driven health plans together with these direct payment clinics that are spontaneously and simultaneously starting nationwide might well prove to be the twin engines propelling us out of this "perfect storm."

An op ed in the Wall Street Journal by economist Alan Enthoven once asked, "Where are Healthcare's New Honda's?" With more clinics like these offering services costing between an oil change and a brake job, my answer is that they are just arriving – and they are patient driven.

How cash only clinics reduce costs

Cash only clinics can reduce cost substantially. Operating expenses for a family physician vary from practice to practice depending on the locale, the extent of services that are offered, the equipment, etc. Some have their own lab and X-ray machines – many do not. According to the Medical Group Management Association, the average family physician's take home income is about $150,000 per year. Overhead is typically around 65% or $250,000.

One physician contemplating quitting medicine was quoted in last summer's *Time* magazine issue, "The Doctor is Out," as saying, "Our income is completely controlled by the government but we have no control on our expenses." In contrast, I rely on appreciative neighbors for my income, and by avoiding contracts with third party payers I have a handle on cost. My overhead is about one-third that of the typical family practice which in absolute dollar terms is over $150,000 per year – more than the typical family physician's take home pay.

According to MGMA, the average number of FTE's per family physician is about 4.4 and the annual personnel cost is about $150,000. Mine are 1.2 and $30,000, respectively. As I mentioned earlier but is worth repeating, the average cost per visit over the last six months including the professional fee, tests, and medicines has been $51.53 per patient.

If we could suspend political reality for a moment and imagine that all 300,000 primary care physicians did direct payment, the national cost savings would translate roughly into $50 billion savings on the doctor's end alone. This excludes the savings to the insurers.

If there were more reasonably priced clinics like ours around, the uninsured would not have to use ER's for their medical care and Medicaid programs could stop paying for routine medical care for many of their recipients. This would decrease pressure on ER's and would free them up to do what they do best – care for emergencies. It would also decrease Medicaid costs, which are busting many state budgets – including Tennessee's.

The biggest savings, I believe, would come from changing the consumer mindset. Instead of shielding consumers from the true cost of routine medical care with low co-pays and low deductibles, if average Americans had to pay everything up to a fixed, meaningful amount, they would be more cost conscious. My uninsured and high deductible patients feel the full cost of their routine healthcare decisions and find the best value for their dollar as they do with any other economic decision affecting their households. Many ask me to quote a fee before agreeing to be seen. Then they insist that I provide a thorough justification for the diagnostic strategies and treatment I recommend. In a sense, the uninsured and those who have high deductibles are the prototypes for consumer-driven healthcare. Applying the sum of all of these savings to the nearly half billion primary care doctor-patient encounters each year could significantly curb the cost of healthcare for everyone and make it more available and affordable for the uninsured.

I once saved an observation about reasons for waste in bureaucratic medicine (I have since lost the reference). Its *modus operandi* contrasts starkly with the lean operations of these new direct payment clinics.

> "The great Toyota production engineer, Taiichi Ohno, referred to any activity that adds cost but does not add value as **muda**. There are seven categories of **muda.** As applied to healthcare, they are as follow:
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> • **Delay**: Idle time waiting for pre-certification for hospitals, consultations, tests.
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> • **Movement**: Unnecessary physician visits for referrals and lab tests.
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> • **Oversight**: Having one worker watch another worker as in utilization review.
>
> • **Inspection**: Having one worker inspect the work of another worker after it has been completed as in HCFA retrospective case review.
>
> • **Rework**: Performing the same task twice as in second opinions or refiling claims.

> • **Overproduction**: Requiring unnecessary products as in defensive medicine or processing unnecessary information, e.g. as required by HIPAA.
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> • **Poor or Defective Design**: Design goods that do not meet customer needs, such as HMOs, Government or Employer-sponsored health care, and requiring RBRVS, CPT, DRG, and ICD-9 coding schemes."

One of the biggest savings might not be financial. According to the American Hospital Association's *TrendWatch*, over 120,000 nurses are currently needed to fill vacancies in our nation's hospitals. According to a JAMA study, there will be a shortage of 400,000 nurses by the year 2020. Again, suspending political realities to make a point, if all primary care physicians could reduce their staff by three employees, there would be 900,000 more healthcare workers who would be available for direct patient care rather than wasting time pushing paper.

Maybe it *is* time to change the political reality. After all, John F. Kennedy once said:

> "The problems of the world cannot be solved by the skeptics or the cynics, whose horizons are limited by the obvious realities. We need people who dream of things that never were."

Now we can talk about healthcare

On April 18th, the New York Times carried a thoughtful article by Senator Clinton entitled, "Now Can We Talk About Healthcare?" As a frontline physician, I believe she is right when she says, "We need care to focus on the patient" because "studies show that when patients have a greater stake in their own health, they make better choices." I too believe that "the present system is unsustainable."

However, I would have to disagree with her that "every other industrialized nation has…health care that's always available for every citizen." The evidence shows instead that universal health coverage does not universally guarantee timely, quality medical care. Although beautiful, egalitarian, and

noble in aspiration, universal health insurance has proved ugly, elitist, and ultimately inhumane in practice.

According to an article from London's Sunday Times, over one million Brits are awaiting elective surgery, despite its National Health Service having so many workers that it is the third largest employer in the world. There is such a backlog of surgeries that the government is subcontracting the work out to other European nations. The National Health Service, however, insists it's making improvements, stating on its website, "Already more than three out of four inpatients are admitted within *three months* (emphasis mine) of seeing their GP, dentist, or optician." Soothing words perhaps for the Brits, but with delays of this magnitude we Americans would be suing for malpractice.

The following quote (again from its own website) is even more incredible. "If you are suffering from chest pain for the first time and your GP thinks this might be due to angina, you will be assessed in a specialist chest pain clinic within two weeks." Faced with a potentially fatal medical condition, Americans would never tolerate such delays in care.

Despite many Americans' infatuation with Canada's system, it appears to be no better than Britain's. Canada's own National Post has reported median waits for a CAT scan of 5.2 weeks, for an MRI 12.4 weeks, and for an ultrasound 3.2 weeks. The average time it takes for a Canadian GP to refer a patient to an ophthalmologist is 15.8 weeks with another 10.8 weeks elapsing before the eye specialist actually initiates treatment. According to the Canadian Medical Association Journal, the median time from a mammogram to a mastectomy is about 14 weeks, long enough for a localized cancer to metastasize.

By comparison, just before Labor Day last summer an uninsured patient of mine came in with a worrisome cough. We obtained a chest X-ray that day which showed a shadow on the periphery of his right lung – potentially a curable lesion if cancerous. A diagnosis was made, and the patient was referred to a thoracic surgeon, who removed the cancer 4 ½ weeks from his visit to my clinic. I still see him periodically, and there is no evidence yet of recurrence or spread of the tumor.

Our own Tenncare system, often touted as a model in Medicaid efficiency, is about to bankrupt the state. It costs approximately $5,500 per person or $22,000 for a family of four. In a February 2004 Johnson City Press editorial, I made the following observations.

> "Many Tenncare patients tell me they choose our clinic because either their assigned providers don't have any openings for several weeks or they don't have a provider at all. Should we be surprised considering the pittance Tenncare pays physicians?
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> To pay for all the overhead insurance and government impose on their practices, physicians have to stack their schedules with frequent visits from patients with simple chronic problems.
>
> So much is wasted in this petty political game of 'you pretend to pay us and we pretend to care,' that there is little left over to pay specialists for the really sick. One of my patients with severe rheumatoid arthritis cannot get an appointment with a rheumatologist who accepts Tenncare until August.
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> In addition, about as many dollars are spent settling the small claims for routine office visits as the doctor receives for his time."

Several weeks later, Governor Bredesen in his State of the State address announced a fundamental shift in policy by introducing greater accountability at the point-of-care. He was quoted as saying, "the only way you manage utilization effectively is to have some economic skin in the game at the point of sale," calling on "able-bodied adults…to pay something." The consulting group McKinsey & Company has proposed increasing physician visit co-pays up to $32 for this "able-bodied" population – a little less than the average visit at PATMOS.

It seems that centralized bureaucracies simply cannot manage healthcare. Medical decisions are much too complex and personal to entrust to distant bureaucrats many of whom lack basic medical knowledge. The most efficient and humane solution is to allow ordinary Americans to manage their own care by giving them control over their healthcare dollars. It is, after all, their money and their health. They *should* control both.

Senator Clinton goes on to say, "It will…take the whole village to finance an affordable and accountable health system." The "villages" of Great Britain, Canada, and Tennessee might have the power to set prices and thus make healthcare more "affordable," but they cannot contain the costs. Markets, even in healthcare, will not be mocked, and costs will be extracted in terms of longer and potentially fatal delays and fewer innovations. Already more physicians at the height of their careers are choosing early retirement and fewer of our brightest students are selecting medicine as a vocation.

To whom would you rather entrust your care – a heart surgeon who is angry that his (or her) talents were commandeered in mid-career or one willing to acquiesce to the bureaucracy? Without caregivers, there can be no care – irrespective of village mandates. For no one - not even Representatives or Senators - can coerce talented and medically skilled citizens to care.

From my experience with Tenncare, there seems to be little accountability with government run healthcare. While working in a Tennessee ER for 4 years, I noted that over 80% of adult Tenncare patients smoke cigarettes. Given that a pack-a-day habit costs roughly $1,000 per year, these Tennesseans could pay for about 20 visits to our clinic with the money they would save from quitting. Indeed, any objections to paying for their own routine medical care at clinics such as ours could be seen more as a problem with their priorities than with the price.

One 40-year-old nurse with a heart attack I cared for opted for a higher paying job without insurance than one with insurance because he knew that if he did have a catastrophe he would immediately be placed on Tenncare. He was right. I happen to know that his family still owns 70 acres of land outright. I have observed some Tenncare recipients driving late model vehicles to my clinic such as Toyota Sequoias and Honda Accords. I have no problem with their smoking cigarettes or owning vast tracts of land or expensive vehicles – just not at taxpayer expense.

Corruption and waste seem to be endemic in villages, but not at neighborhood cash clinics such as ours that don't presume upon other taxpayers. Every day I am repeatedly and directly accountable to my patients. If they don't

value my service, they go elsewhere. In Canada, that "elsewhere" happens to be the United States.

What government can do to assist
development of PATMOS-type practices

If policies promoted the development of direct payment clinics instead of hindering them, the current grassroots movement in low-cost clinics would probably spread like wildfire. I might then be able to find another physician to join me and thus extend the clinic's hours to my community. Then my patients wouldn't have to complain about getting charged $750 by the ER for repairing a laceration that I would have repaired for about $200 – or getting charged $400 by the ER to X-ray a boy's arm to tell him that a BB easily palpable near the skin was indeed located in his arm, when I removed it the next day for $100 (which included the price of the antibiotics). If physicians weren't so afraid of running afoul of arcane and capriciously enforced Medicare regulations, many more, I believe, would start similar clinics.

So what can you as Congressmen and Senators do?

First, you can change Medicare's "opt out" clause. Medicare regulations make physician coverage for my practice practically impossible. In order to care for the uninsured cost-effectively, I had to "opt out" of Medicare. Otherwise, I would have to turn away any Medicare patients willing to pay me directly for my services. No other physician in my area with skills compatible with mine has "opted out" of Medicare. Therefore, I cannot be available to my patients beyond office hours (otherwise I would be on call 24/7, 365 days a year), and I have to shut the clinic down completely when I take a vacation or attend meetings like this one.

Two weeks ago an emergency physician from Georgia spent the day at PATMOS trying to get an idea what it will take for him to get started part time in a practice similar to this. He still wants to continue practicing ER medicine until the practice can sustain his income needs. In order to do that, I advised him to turn away all Medicare beneficiaries, because according to Medicare's "opt out"

clause, he cannot both bill Medicare in the ER and contract privately with Medicare beneficiaries in his clinic.

Medicare law insists that a new patient with an "urgent" condition be turned away from the clinic. Over a year ago a Medicare beneficiary who did not have a primary care physician came to our clinic with a one-month history of weight loss and cough. Had I referred him to the ER, they would have found the mass on chest X-ray but would not have been able to evaluate it more fully. They would have given him the names of doctors with whom he could follow-up, which would have just delayed his care. As it was, the patient was diagnosed with small cell cancer and within about 2 weeks began chemotherapy. I'm not sure if Medicare would consider his condition" urgent." But how could I turn him away because of a Medicare regulation I don't understand? I had to do the neighborly thing. Otherwise, the patient might not have had a few more good months and enjoy his last Christmas with his family.

Medicare patients who want to be treated at direct payment facilities because they are unable to obtain an appointment in a timely fashion with their regular physician might either wait until their condition becomes so severe that they require costly in-patient care or resort to the emergency department earlier in their illness than is really justified. The latter option would be unnecessary for a routine problem, many times more expensive than my clinic, and inordinately time consuming for the patient.

In order to prevent treating a Medicare beneficiary by mistake and risk a fine or imprisonment, such a physician has to require all patients to sign an appropriate document stating that they are neither Medicare beneficiaries nor Medicare eligible at the time of the visit. This is an excessive burden to the clinic and inconvenience to its patients.

Quitting emergency medicine so as to "opt out" of Medicare is certainly not desirable for most emergency physicians. Even those who want to cut back on hours in the ER would like to do so slowly. We enjoy the challenges and rewards of the specialty and more would probably extend their careers substantially if it weren't for the "opt out" clause. In addition, the measure

requiring a two-year hiatus for all who dare to "opt out" is certainly a draconian disincentive to test the waters of caring for the medically uninsured.

Second, curtail the tax exemption for low co-pay, low deductible insurance. If companies want to purchase these for their employees that is fine, just not at other taxpayers' expense. Holman Jenkins of the Wall Street Journal perhaps has said it best:

> "The average family of four now pays about $1600 a year in taxes to cover the cost of a health-insurance subsidy to *itself*. No real gain to anybody occurs: We just push checks around to conceal from people the true cost of their healthcare. How bad this has become is lost on most Americans …. It is also grossly regressive: A family earning $100,000 a year gets $2357 to help pay for medical insurance; a family earning $15,000 gets only $71…. The only reform that stands a chance is one that dismantles the nutty system of tax subsidies that fuel health care inflation by commanding an unnatural urge to channel every ache, pain and prescription through a third party payment bureaucracy."

Third, allow Americans to roll over other assets such as IRA's into their Health Savings Accounts to provide immediate coverage for the high deductibles.

Fourth, promote transparency in pricing by hospitals, especially if they are non-profit. Two non-profit hospitals in Urbana recently lost their tax-exempt status because townspeople were able to demonstrate price gouging of the uninsured and draconian collection practices. The hospital nearest our clinic charged an uninsured patient of mine for a colonoscopy twice what they charged the insurance company of his wife. A patient I diagnosed with appendicitis and referred directly to the surgeon (as opposed to the ER where he would have incurred an even higher bill) was charged $5,500 by this hospital even though he went home the same day as his surgery. I suspect Medicare and Tenncare pay considerably less for the same treatment. Although this hospital is non-profit, it refused to discuss discounting rates for the uninsured at our clinic.

Extending care to all direct payers (including the uninsured)

A business sketch

There is a niche somewhere in between urgent and emergent care that is particularly attractive to emergency physicians whose careers on average cover less than a decade (due to the phenomenon many call "burnout"). It could allow us to use most of our skills and experience under less duress and without doing graveyard shifts. Originally, my clinic started this way, but financial limitations and time constraints forced me to scale back my services. Such an option would extend ER docs' careers by providing an opportunity to use most of our skills and knowledge more fully than most other options currently available.

There is probably no other group of physicians today more qualified to take care of the medically uninsured than ER docs. We provide a broader range of medical care than any other specialty. We are able to treat from the very young to the very old, from head to toe, from the chronic to the acute, from routine ailments such as ankle sprains and sore throats to emergencies such as major trauma and heart attacks. We are part anesthesiologist, part dermatologist, part gynecologist, part internist, part neurologist, part ophthalmologist, part orthopedist, part otorhinolaryngologist, part pediatrician, part psychiatrist, and part surgeon. After about a decade of practice, there are few diseases within medicine that ER physicians haven't treated and, short of major surgery and skills reserved for other specialists, few procedures that we haven't performed. Yet after the first decade of our careers, many are ready to call it quits. Most find less stressful jobs that do little justice to their unique experience and skill.

I believe that this talent could be better employed in fully equipped urgent care centers that approximate small rural ER departments in capabilities. I have worked in small, rural ER's as well as large urban ones that treat major trauma. I understand first hand the capabilities of both. In my opinion, establishing this type of facility throughout the country is an idea whose time has come, especially considering the ever-increasing cost of medical care and the 44 million uninsured. Indeed, four similar facilities (albeit hospital-associated) are already operating in New Jersey.

I predict that there would be a ready supply of physicians for facilities such as the ones that I envision. I believe that near-burned-out and burned-out emergency physicians would be willing to contribute their skill and knowledge in less stressful settings that don't require 24 hour a day, 7 day per week coverage. The burden on urban ER's would be reduced. Rural hospitals could replace much of their ER coverage with hospitalists capable of covering the whole hospital 24/7. And best of all, more urgent and semi-emergent conditions could be treated skillfully and definitively. Should true emergencies happen upon the premises (ambulances would not be allowed to transport emergency cases to such facilities), they could be adequately stabilized and sent by critical care transport to an appropriate hospital.

This presents a win-win-win situation for everyone. Seasoned emergency physicians would not waste their talent. Hospitals could use their resources more efficiently. And most importantly, patients, especially the uninsured, would be able to take advantage of the comprehensive skill of a retired or semi-retired emergency physician in a more cost-effective setting.

I have sketched out a plan for such a clinic in a market larger than Greeneville. A clinic such as ours initially requires only one trained clerical person besides the physician. At between 3 and 4 patients an hour, it becomes cost effective to hire an office assistant. It would require one other physician with a background similar to mine to alternate 12 hour days. We could also take appointments on our days off within a small space in the clinic. Neither an X-ray machine nor a lab would be necessary. In fact, there is a strip mall in a nearby town with a chiropractor willing to take X-rays for us and with a satellite draw station for a regional lab company. Only about 1600 square feet would be necessary. Much of the office equipment could be purchased second-hand at low prices as I did when I started PATMOS.

Given this, I would estimate that start-up costs would be between $150,000 and $200,000 and within 6 months the clinic would be self-sustaining. This assumes a generous amount for advertising, initial office costs, and a reasonable

income for physicians and staff. The clinic would be self-sustaining around 1.5 patients per hour.

The government would not need to foot the bill for any of this. I suspect that there are plenty of wealthy stakeholders with enough of an interest in preserving private medicine who would be willing to capitalize such a venture reasonably if not generously once they have learned of its potential. Perhaps clinics such as these are what Harvard Business School professor Clay Christensen had in mind when he coined the phrase "disruptive innovation." They are indeed a cheaper, more efficient way of providing professional services initially directed at low-end users that will likely catch on soon in the mainstream and eventually come to dominate the primary medical care market.

Direct payment primary care practices like these are pretty simple, really. But then, as President Reagan once said, "There are no easy solutions. Just simple ones."

All they require is being a neighbor.