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## If All Doctors Had More Time to Listen

By JULIE WEED

WHEN Dr. José Batlle met his 93-year-old patient in her small Bronx apartment, she didn't have much furniture beyond a small TV, a sofa and a wheelchair. What she did have in abundance were pills — 15 types from a variety of doctors, including a pulmonologist, a cardiologist and a gerontologist. He discovered that some medicines had expired, others were unnecessary and some were dangerous if taken together.

Sitting with his patient and her son, Dr. Batlle cut the number of her medicines to four. He also gave the family his personal cellphone number.

Before coming to see him, the woman had endured several emergency-room visits and hospital stays. With Dr. Batlle, she was able to avoid all of that.

Calling a doctor on his cell? No waiting for an appointment? It's the type of service that Dr. Batlle tries to offer to all of his 1,500 patients. "I prefer to keep them healthy than treat them when they are sick," he says.

The efforts of Dr. Batlle and other primary care physicians may get a boost at the federal level. The Obama administration is considering ways to persuade medical students to pursue careers in primary care by raising their pay, and is channeling them to work in underserved [rural areas](#). And the White House has already set aside \$2 billion for community health centers through the [economic stimulus package](#).

But more far-reaching [health care reform](#) remains an uncertainty, and in the interim a small but growing number of doctors are trying to take matters into their own hands.

By stepping off the big-clinic treadmill, where doctors are sometimes asked to see a different patient every 15 minutes, Dr. Batlle has joined the vanguard of physicians trying to redefine health care. These doctors spend more time with patients, emphasize prevention and education to keep them healthy and can handle many medical problems without referrals to specialists.

In many cases, this kind of care can reduce a patient's medical bills. That's more crucial than ever: according to a [study](#) published online by the American Journal of Medicine, 60 percent of all bankruptcies in the United States in 2007 were driven by health care costs.

Exact numbers are hard to come by, but doctors involved in this movement, called "patient centered" practices, say its popularity is growing.

"I travel to a lot of medical conferences, and I'm meeting more and more doctors embarking on this path," said Dr. L. Gordon Moore, who runs [IdealMedicalPractices.org](#), a program to help small practices become more innovative and efficient. The Web site [IdealMedicalHome.org](#) has about 800 doctors who post and trade ideas, while more than 700 physicians have adopted methods from [HowsYourHealth.org](#). Many of these doctors see fewer patients per day than they did before.

To make personalized care possible in an era when compensation is often tied to the number of patients they see, doctors use technology to streamline processes and reduce administrative costs. Dr. Battle, for example, uses online appointment scheduling and manages his medical records electronically. He prescribes medications from his computer and offers virtual visits by phone and e-mail.

It cost Dr. Battle about \$25,000 to buy the technology to make all of this possible, but he estimates that he saves close to \$100,000 a year in salaries and billing costs. And he has made enough money to begin renovations on a new office in Washington Heights in Manhattan.

The model seems to be working, according to a 2008 [study by Dr. John H. Wasson](#) at Dartmouth Medical School. His research showed that patients in patient-centered practices were more likely to say they were informed about how to manage chronic diseases and got the care they needed, compared with those in a national sample of medical practices. They also were less likely to say they had to wait for an appointment.

“If the goal is to deliver patient care when and how they want and need it, this is the way to go,” Dr. Wasson said.

Of course, even doctors in this movement acknowledge that it is not a panacea for the country’s health care problems. Privacy advocates warn that electronic patient records can be breached, and computer glitches can make patient records inaccessible for hours. Big clinics can be better for people who have several health problems and need easy access to a variety of specialists. Moreover, some doctors may not want to leave a big clinic because they feel they lack the technical or business skills they need — or because a salaried job there may be more stable in this economy.

And while the patient-centered movement is growing, the nation may not be able to afford to have all its primary care doctors reduce the number of patients they see. Across the country, primary care physicians are in short supply, in part because average salaries for family practitioners are the lowest of any medical specialty. According to a 2008 survey of physician salaries by the American Medical Group Association, their average annual salary is \$201,555, versus \$356,166 for a general surgeon and \$614,536 for a neurological surgeon.

“Medical school loans can be so high, you need to be a specialist to pay them back,” Dr. Battle said. “But our country doesn’t need yet another [sleep apnea](#) specialist.”

LILI SACKS, a primary care doctor in Seattle, says she began thinking differently about her work on the day she realized she was beginning each appointment with the words, “Sorry I’m late.”

Scheduled to see as many as 25 patients a day at a large clinic, she lacked the time for thorough examinations and discussions. Because of this, she said, primary care doctors are often forced to order tests and send patients to specialists.

“Could I have helped some people without specialists and tests? Absolutely,” said Dr. Sacks. “Would it have saved the patient and the insurance company both money? Absolutely. Is the system set up for the best care and cost efficiency? Absolutely not.”

Dr. Sacks said she worried that seeing so many patients would lead to errors. Last year, she moved to a clinic that focuses on longer patient appointments, 30 to 60 minutes. This translates to 10 to 12 patients a day. Patients also communicate directly with her by phone or e-mail.

During those longer appointments, Dr. Sacks can perform basic lab tests and simple procedures, so patients see fewer specialists.

“I probably head off a handful of emergency-room visits and hospital stays every month because patients can see me as soon as they have a problem, and I can be thorough rather than rushed,” she said.

One patient who avoided the emergency room was [Todd Martin](#), a store manager in Seattle who went to Dr. Sacks’s clinic on a Saturday.

“I couldn’t stop coughing and was having trouble breathing,” Mr. Martin said. “They were able to see me and give me a chest [X-ray](#).”

Mr. Martin said he spent \$40 for the resulting prescription but the rest was covered by a monthly fee he pays Dr. Sacks. “A weekend visit to the E.R. would have easily cost \$1,000,” he said.

Dr. Sacks charges patients a direct monthly fee of \$54 to \$129 based on age, and she doesn’t take insurance. Her office calls its philosophy “direct practice” because it’s a direct contract between doctor and patient. But she advises patients to obtain insurance plans to cover large, unexpected health costs like those to treat [cancer](#) or a [heart attack](#).

“We say it’s like having a car and paying for your own oil changes and tuneups, but getting insurance in case you need a big repair,” she said.

Dr. Garrison Bliss, who in 2007 founded the group where Dr. Sacks works, has offered direct-practice services since 1997. He says patients can save 15 to 40 percent of their medical costs by using this model, based on his examination of insurance rates and his belief that good primary care can fill most of a patient’s needs.

Insurance plans that cover every little thing can be very expensive, Dr. Bliss said. He said that a patient who paid an annual fee at his clinic and took out a higher-deductible insurance plan would usually come out ahead, even if the patient’s health needs meant that he or she had to pay the entire deductible.

Dr. Bliss’s office operates with just two administrative employees for seven doctors. He estimates that if he took insurance, one or two administrative workers would be needed per doctor.

Insurance administration costs can take a big bite out of a practice’s revenue. A recent [Weill Cornell Medical College study](#) found that a third of the money received by primary care physicians pays for interactions between a doctor’s practice and patients’ health plans.

Patricia Rogers Caroselli, a retired assistant principal who is a patient of Dr. Sacks, dreaded going to her former clinic. “The waiting room was always noisy and crowded,” she said. In the examining room, she felt that she should “get in and out and not waste the doctor’s time with questions,” she said.

In contrast, she said, she appreciates the friendly calm of Dr. Sacks’s new surroundings and the personal attention. “Everyone should have this kind of patient care,” she said.

Dr. Sacks said the financial mechanics of the direct-practice model match her medical goals. When she was compensated based on insurance, she was paid every time she saw a patient. Now, if she can use education and prevention to reduce office visits, she and her patients benefit, she said.

“Having more time to sit with each patient has made me a better doctor,” she said. “I had a disabled patient that I saw for 13 years. Until she came to my new clinic, I never had the time to learn the details of her accident and the resulting complications. I was always treating whatever the immediate concern was.”

TECHNOLOGY has helped many doctors reduce costs. Dr. Battle says he has been building his arsenal of technology solutions one by one, with “lots of trial and error,” for eight years.

Recently, he saw a 52-year-old patient with [hypertension](#). As he examined the patient, noting [blood pressure](#) and other vital signs, he entered the information into his laptop computer to add to the patient’s electronic medical record. He also typed in the codes for billing and insurance.

The patient wondered if he was due for a prescription refill, so Dr. Battle checked his computer again, found that he was, and hit a button to send the refill request to the pharmacy. As the patient left, Dr. Battle hit the keyboard to send the bill electronically to the insurance company.

“He’ll even go to the Web to schedule his follow-up appointment,” Dr. Battle said. “I don’t pay a receptionist to sit and answer phones.”

Dr. Battle says other doctors could outfit an office for less than the \$25,000 he spent on technology.

“Most doctors think they need to hire two receptionists, a billing person and two nurses to run a primary care office,” he said. “But they can learn about these technologies from other doctors, and the software salespeople do some training.”

Some physicians hire consultants to find and install the right equipment. Doctors who want to switch to electronic health records may also receive [financial support from the government](#) through the stimulus package.

By using new technology and streamlining processes, small primary care practices can reduce their costs to half of what a typical practice pays, from about 60 percent of income down to 30 percent, Dr. Wasson said. He said that doctors who focus on reducing their costs can see fewer patients without sacrificing income. Dr. Sacks said she and her colleagues didn’t have to take a pay cut when they moved to Dr. Bliss’s practice.

As Congress and the Obama administration begin to focus more closely on health care, some primary care doctors are weighing in. Dr. Bliss, for instance, has been to Washington twice in the last month to share his ideas with legislators. He knows he’s in a debate with powerful voices, especially insurance companies and [hospitals](#). So he and other doctors are encouraging patients to speak up as well.

“We need to bring the patients to the barricades with us,” Dr. Battle says.

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