SECOND OPINION

BY ROB LAMBERTS, MD

A reasonable defense of direct primary care

"I defended your honor last week," my patient said.

"Thank you," I said, curious. I hadn't known my honor was under attack.

The defender of my honor was a woman who has been my patient for 15 years, who has gone through terribly difficult life situations, who has multiple health and emotional conditions, and who is on Medicare. Apparently, a nurse was in her home helping with the care of her mother, who is also a patient of mine. When the nurse asked the name of her PCP, my patient gave my name and the nurse reacted negatively. "Rumor has it," the nurse told her, "Dr. Lamberts left his old practice so he could charge a lot of money and take care of wealthy people."

"I stood up and shook my finger at her," my patient explained. "You don't know what you are talking about! Dr. Lamberts has taken care of us for years, and I wouldn't ever have another doctor. He doesn't charge a lot, and when I was having problems with money, he cut my fee in half." She was agitated even talking about it, which made me smile. "That woman backed off because both mother and I were upset by what she said. I think she was afraid we'd attack her!"

The misunderstanding my patient defended me against is a common one, but one of many objections people have to the practice model. I faced these objections when I first wrote about my intent to do DPC, and recently these objections were again voiced by Timothy Hoff.

Initially, my response was simply to prove my critics wrong by building a practice that answered these questions. "It can't be done" is best answered with "I did it." But often these discussions take on the tone or tenor of a political or religious discussion. Defenders of DPC (including many DPC docs) are zealous in their defense, emotionally charged because this practice is life-changing. I regained my life and my love of medicine when I switched to the practice model. So when someone attacks DPC, it's akin to having someone attack your spouse, your children, or your faith. But such discussions aren't constructive, because the passion in the response makes it appear emotional, not rational.

"What is more valuable to society: giving poor care to 3,000 people or excellent care to 750?"

So I will try to take a rational approach to the criticisms of DPC. I want to put aside passion, listen to criticisms, and address them reasonably. I'll focus on the most frequent objections I hear.

OBJECTION 1: DPC IS ELITIST

This is the objection faced by my patient (and Dr. Hoff's article). The argument is that most people cannot afford the monthly fee, so only wealthy people can afford the care. In truth, I charge between $35 and $75 per month (not $50-$200 as said by Dr. Hoff), based on age. I do not charge more for complicated patients, management of difficult medical conditions. I am in sync with the majority of DPC practices in my billing.

As to the "elitist" criticism, there is a significant difference in the average income in my current practice compared to my old one, but it's the opposite of what is suggested. I serve a lower income socioeconomic population than I used to, there are more self-employed, uninsured, and even unemployed patients. Why is this? I think it is the predictability and transparency of cost that makes DPC appealing. When an uninsured person goes to a traditional fee-for-service practice, won't know the cost of care upfront, and labs and medications are potentially much more expensive than we offer.

There are some who cannot afford even the $35 to $75 I charge. Some of these (like my patient defender) I am able to help by discounting their price, either temporarily (for life circumstance) or long-term. As for others who cannot afford those fees, these problems are not mine to solve, as they are the societal problem of poverty, distribution of wealth, and unemployment that I cannot fix. DPC is a practice model, not a panacea.

Despite this, many low-income

people value my care enough that they find the money to pay regularly. This includes the poor, as well as a sizable Medicare population. I believe that good primary care will often significantly reduce the cost by giving care to problems before they become serious (such as diabetes and hypertension).

OBJECTION 2: DPC IS NOT SCALABLE

I left a practice of 3,000 patients (although that number is nearly impossible to truly quantify accurately), and now have a "large" DPC practice of 750 patients. It's simple math to see the problem: what happens if all primary care doctors make this change? What will happen to the 75% of patients who did not follow me to the new practice? What would happen if 75% of all Americans were left out by their primary care doctors?

This is a real problem that can't be ignored if physicians start changing to DPC in significant numbers. But there are several things that offset the apparent loss of physicians for patients. First, DPC is far better for the doctors, and will likely slow the burnout rates afflicting primary care at this time. An alarming number of doctors are retiring early, quitting medicine for other professions, or avoiding primary care in the first place, something that will itself reduce the availability of primary care doctors. DPC once again makes primary care enjoyable to those in it and appealing to those considering it.

The second offsetting factor is the significant improvement in care quality. I see between 6 and 10 patients per day on average, which is one third of what I was seeing in my previous practice. When I saw the high volumes in my old practice, I didn't feel like I was giving good care to anyone. I didn't have the time to listen, to teach, to work through problems. Now I feel I can give excellent care to everyone in my practice. So, what is more valuable to society: giving poor care to 3,000 people or excellent care to 750? The answer to this depends on how wide the gulf is between the poor care in my previous practice and that in my DPC office. Subjectively, it's not even close from my perspective. Objectively, the very low rate of attrition from my practice says my patients feel the same.

"DPC is far better for the doctors, and will likely slow the burnout rates afflicting primary care at this time."

Finally, I would point out that DPC is not necessarily the endpoint in the evolution of primary care. It is, instead, an innovation of a malfunctioning business model. If DPC grows more and a shortage increases, further innovation will be necessary to close this gap. That does not, however, make the innovation wrong or ill-advised.

OBJECTION 3: WHAT HAPPENS WHEN PATIENTS NEED SPECIALTY OR HOSPITAL CARE?

This objection is based on a misconception of intent: it assumes that DPC is trying to be a global solution for the bigger problems in healthcare. I am not trying to do anything more for my patients than to offer them excellent and affordable healthcare. Doing so can (and does) reduce the need for specialty care, ER visits, and hospitalizations, but it doesn't eliminate it. For this reason, I greatly prefer that my patients have insurance of some sort. But the problem of high-cost specialty and hospital care absolutely needs to be dealt with on a societal level.

A second misconception is that people assume that we are putting DPC up as an alternative to insurance. While this is absolutely not true, it is true that DPC replaces insurance for primary care itself. But I believe that insurance is not only inappropriate for primary care, it is harmful. It's as if auto insurance covered oil changes, tire rotation, and other maintenance and repairs for your car. While this would seem appealing to some, it would significantly raise the cost of repairs, parts, and maintenance because the cost would no longer be transparent. Primary care is a low-cost service with the intent to decrease utilization of the rest of the healthcare system. It is the best chance to decrease unwanted and unnecessary care and reduce cost.

Our current system is terribly broken and in need of innovative ideas to keep it from bankrupting our citizens. While DPC may not be the solution for this, it certainly takes a number of steps towards some desperately needed changes: lower cost, less over-utilization, happier doctors and healthier patients.

And if you don't believe me, I know someone who wants a word with you. ◘

Rob Lamberts, MD, is a board-certified internist and pediatrician who runs Dr. Rob Lamberts, LLC, a direct primary care practice in Augusta, Ga. He also recently gave a TED talk on the DPC model. Have questions about DPC? Email medec@ubm.com.

+ READ MORE **It's time for transparency in medical school costs** PAGE 51