Patient-centric? Third-party payers interfere

Dr. Susman's editorial, "Is your practice truly patient-centric" (*J Fam Pract.* 2012;61:70) struck a nerve with me and, I'm sure, with many other family physicians. I fear that we have allowed too much third-party encroachment into the doctor-patient relationship.

Instead of working directly for (by which I mean being paid by) our patients, we are often working for a third-party payer. The result? In a world of increasing overhead costs and declining reimbursements, our offices have had to achieve industrial-type efficiencies just to make ends meet. This is not conducive to warm, mutually respectful doctor-patient relationships.

The truth is, many physicians *do* use a Web-based appointment and/or preregistration system. Many physicians *have* championed greater access for their patients. Some have jettisoned the third-party payment model and work directly for their patients, while others have found ways of being more patient-centric while continuing to practice within the third-party payment model. I've benefited greatly from hearing from such innovative physicians.

I would encourage your readers to visit www.impcenter.org to learn more about the Ideal Medical Practices Organization. The ideas being developed by this nonprofit group may well help us create truly patient-centric practices.

Jack Shepherd, MD
Matthews, NC

Why aren't we more patient-centric? The short answer is that patients are not our customers—insurance companies and the government are. Keeping them happy is the primary focus of health care today, from medical records to IT to protocols and social services. Third-party payers have so many requirements and expectations that they crowd out whatever time, energy, and resources might otherwise be focused on patient care.

Sadly, in most settings, taking care of patients is a low priority. That reality is accentuated by the fact that fewer and fewer physicians practice independently; for many physicians, medical practice is just a job.

I still own my own practice, but I'm barely hanging on amid the onslaught of requirements.

But what options are there? Those annoying questions Dr. Susman wrote about, that patients are hit with as they walk into a medical office, are mandated. Even electronic medical records, which once seemed so promising, have been turned into data-gathering tools since the government—and the Certification Commission for Health Information Technology—got involved.

Our health care system is imploding from an overwhelming (top down) burden while our leaders sit by.

Keith Stafford, MD
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Seeing patients for less should count as charity care

There's a big problem with No. 1 on Dr. Susman's wish list (A 2012 health care wish list. *J Fam Pract.* 2012; 61:8)—establish a basic universal health care package for every US citizen—Congress would ensure that all the cost savings come from doctors and hospitals.

Once the government gained control, our legislators would have the ability to control physician reimbursement even more than they do now. This would cancel out any possibility of achieving No. 4 on Dr. Susman's wish list: Pay us what we're worth. If you doubt that, just look at the fiasco associated with mandatory coverage of contraception/abortifacients.

Here's what I propose instead:

Step 1 (to be implemented immediately) involves the charitable tax deduction. Because the government mandates that we see Medicaid, Medicare, and TRICARE patients at less than the customary charge, the government should send the physician/

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practice a charitable tax credit for the difference. Physicians and practices would get a tax break (just like other businesses that do charity work), which would encourage more physicians to see these "low reimbursement" patients. The amount paid by the government for the patient's health care should be credited as income to the patient, with the tax liability for this income not to exceed a predefined amount.

For the uninsured, the patient and practice would mutually decide what the patient can pay. The difference between the usual charge and what the patient pays is counted as a charitable contribution tax credit for the physician/practice. The practice then files a form with the IRS, documenting that the patient was given "x" dollars of free services. This counts as income for the patient, who may have to pay a small amount of income tax (or receive less Earned Income Tax Credit) because of this.

In **Step 2,** the president would call for bipartisan groups (1 senator and 2 congressmen from each party). Each 6-person group would serve as a task force, addressing one aspect of health care. There could be one group working on Medicare, one on Medicaid, one on tax credit issues (eg, whether employer-paid health insurance should count as income), etc.

Each group would solicit input from Americans (not just ivory tower university elites) and hold public hearings on its issue, then put forward a proposed solution. This would be a transparent process (no more, "You have to pass the bill to see what's in it") that is also bipartisan. The proposed solutions could be tested in one state first, if necessary, before being implemented nationwide. The elected representatives for each group would be held responsible by the voters, both for arriving at a solution and for its success.

This could work, but it would take leadership, which I would not expect from the current administration.

William Laurence, MD
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We need to hone the media image of family physicians

Does it really make sense for a neurosurgeon to be quoted in a news story about a new treatment for diabetes or prevention of obesity? Some reporters think so, leaving primary care physicians frustrated at the media's lack of understanding of their broad range of expertise.

The media influences public views and behavior, with the help of popular public figures in various fields of specialty. One example is CNN's selection of Sanjay Gupta, MD, an assistant professor of neurosurgery at Emory University School of Medicine and a medical correspondent who discusses primary care and public health topics--but rarely talks about neurosurgery. Another example is Mehmet Oz, MD, host of the popular Dr. Oz show, who discusses migraines, cancer screening, and exercise, but not cardiothoracic surgery—his specialty.

Besides playing up the importance of such specialists, the media sometimes portrays primary care physicians negatively. Consider the now-defunct TV series, *Becker*, whose lead character was a twice-divorced cynical doctor who was always annoyed by his patients. This is in sharp contrast to the TV doctors of previous generations, including an admirable general internist (*Dr. Kildare*) and a beloved family physician (*Marcus Welby, MD*).

We need to change the perception and role of family physicians in mainstream media. Doing so, however, requires a multitiered approach. One strategy would be for a coalition of family physicians to partner with leaders in entertainment and educational programming. Another strategy is simply to speak up.

Specialists like Dr. Gupta and Dr. Oz have made great strides in the public arena. It's time for family physicians to step up. Let's make ourselves available to our local press by, say, writing to local newspapers and suggesting that if they ever need an expert on primary care issues such as diabetes and migraine, we'd be happy to do an interview. Who knows who else might pick up the name of a doctor whom they had read about or seen on TV?

We can have a positive impact on the thoughts and actions of the public (and our colleagues in the medical community). We simply need to reach out to members of the media and speak up.

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Partnering with leaders in entertainment and educational programming is one way to change the perception of family physicians in mainstream media.