

**MICROMANAGEMENT**

# Faltering Family M.D.s Get Technology Lifeline

*Doctors Think Small  
To Revive Solo Role  
For Primary Care*

By GAUTAM NAIK

ROCHESTER, N.Y.—After eight years as a staff doctor at a hospital-owned medical practice, Gordon Moore began to really dislike his job.

To increase revenue, the hospital pressured him to see more than 30 patients a day, usually for 15 minutes each. Many patients couldn't get appointments for weeks. Dr. Moore determined it took 19 separate actions and 253 feet of corridor-walking to order a prescription refill. He says he was so rushed he often failed to provide the best medical care, and once mistakenly prescribed a blood-pressure drug for a toddler.

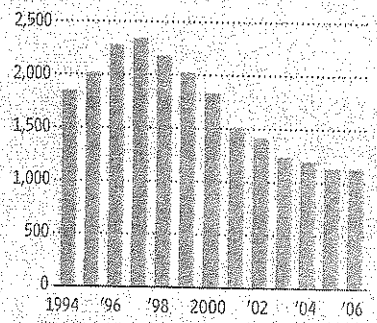
So in early 2001, Dr. Moore took a risky step. He borrowed about \$15,000 to start a solo medical practice in a tiny space with no nurse, receptionist or waiting room. He bought computer software to help him track patients' appointments, illnesses and medications, and to process insurance claims.

Patients at his "micropractice" can call or email to get appointments the same day. Visits last 30 minutes. Dr. Moore can be reached day or night on his cellphone. To refill a prescription, he walks "zero feet," he says, and taps a few keys on his laptop. "I was able to build a Norman Rockwell practice with a 21st-century information-technology backbone," he says.

Dr. Moore belongs to a small but growing number of physicians converting to high-tech, low-overhead practices to try to preserve a disappearing style of care often provided by lone family doctors. They are working to counter a sustained decline in primary-care medicine, long the mainstay of

**Unhealthy Trend**

Fewer U.S. medical-school graduates are filling family-medicine residency positions:



Source: American Academy of Family Physicians

the U.S. health system.

Primary care doctors—family physicians, general practitioners, pediatricians and obstetricians—address patients' health comprehensively and usually over a long period of time, aiming to catch problems early on. Their numbers have dropped by half in the past decade, according to a series of surveys by the American Academy of Family Physicians.

A series of surveys of several thousand doctors by the Center for Studying Health System Change, a nonpartisan

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san Washington, D.C., group, found that primary-care physicians made about \$121,000 in 2003, about a third less than most specialists, and were losing ground.<sup>1</sup> Their inflation-adjusted average income dropped by 10% in the previous eight years, the survey found, while specialists' income was stable. Today, only about a third of doctors in the U.S. are primary-care physicians, compared with roughly half in most other industrialized countries. Studies have shown that primary care tackles many medical problems early on, before they turn into difficult and expensive-to-treat conditions. That partly explains why other countries spend far less per patient, often getting similar health results.

## Harnessing Technology

Some physicians and institutions are trying to harness technology to make family practices more manageable and profitable for doctors. In April, the American Academy of Family Physicians attracted 300 applicants when it offered to put 20 primary-care physicians in a pilot project to help better manage patients and their ills. In Washington state, a dozen family-health practices have linked up on a private high-speed network. They all use electronic records, give same-day appointments, and offer patients email consultations for a \$7 monthly fee.

In a blog called Solo Practitioner, Vincent Pedre exhorts fellow micro-practice owners to "automate, automate, automate! That is the name of the game. Make everything automatic, including billing."

Going solo isn't always an easy sell. Some doctors aren't keen to give up the financial security of belonging to a larger, salaried practice. Many aren't tech-savvy or good at organizing things for themselves. Most who take the plunge initially find it hard to sign up patients, and many make less money than they did before.

Gary Seto, author of the blog SoloDoc, quit his job at Kaiser Permanente three years ago and started a one-man practice in South Pasadena, Calif. After losing money for two years, he scaled back to part-time and only makes a fraction of what he used to. In a recent blog, he writes, "That's the tradeoff. But it's much more enjoyable to me and my patients."

Dr. Moore, 46 years old, says he has persuaded about 60 physicians to officially adopt his model. He doesn't charge doctors to use his idea, but a year ago he received a two-year, \$850,000 grant from the Physicians' Foundation for Health System Excellence in Boston to promote the approach. A local business group in St. Louis has been pushing his model to doctors there. As his evangelizing takes up more time, he has cut his own practice down to part-time.

Dr. Moore never intended to go solo. In the early 1990s, he started at a



Ms. Arazy during her appointment with Dr. Moore.

physicians group practice owned by Highland Hospital in Rochester. Two years later, he says, the hospital asked the doctors to increase revenue by scheduling 32 patients a day, up from an already high 28.

"We were given monthly sheets showing how much money we were losing individually and collectively," recalls Dr. Moore, noting that other hospitals adopt similar measures. "It felt extremely uncomfortable."

The practice wasn't a big financial success because it was inefficient, he says. For example, if a patient called and asked for an appointment, three separate staff members—receptionist, nurse and then doctor—would often have to be consulted on the urgency of the complaint before a date and time could be set. He figured out that medical files were stored in 39 different places.

The Highland-owned practice, like many others, also paid 6% or more of its gross revenue to an outside firm to process medical bills—and still wrote off a large number of claims that insurance companies rejected.

## Taking a Toll

Doctors at the Highland practice agreed to see more patients, but things got worse. The phones rang constantly. Though Dr. Moore worked 12-hour days, he says, his patients began to complain about being hurried through appointments. He sometimes dispatched patients with minor ailments to the hospital's emergency room.

One day Dr. Moore intended to give a fluoride supplement to a toddler but instead prescribed a blood-pressure drug called Florinef. A pharmacist caught the error. But the incident rattled Dr. Moore, who took responsibility for the mistake but felt the constant rush of patients was taking a toll.

The doctors' compensation plan changed from a guaranteed salary to a share of the practice's revenue, making it less secure. "It seems that all of the

conversations in our office were about money," Dr. Moore later wrote in a medical magazine, *Family Practice Management*. "A good doctor, it seemed, was one with high visit volume."

The network to which Highland belongs, Strong Health, acknowledges inefficiencies Dr. Moore pointed out and says computerizing records has helped address them. "Is micropractice a way to further simplify? We agree it's a concept worth testing," Raymond Mayewski, director of the Center for Primary Care at Strong Health, said through a spokeswoman.

In the summer of 1998, Dr. Moore attended a talk on how technology could be used to improve medical "work flow," and another by a Massachusetts Institute of Technology professor who talked about how a local bike shop got lean by cutting its area by 75% and still thrived. The professor suggested similar stripping of overhead would work in other fields.

In early 2001, after considerable anxiety about the decision, Dr. Moore opened a solo practice in an airless 150-square-foot room in a small office building. By keeping a tight lid on overhead costs, he hoped to see fewer patients—no more than about a dozen a day—and provide them better care, and still earn a decent wage for a doctor.

On his first day, the office phone rang in the middle of a patient appointment. He says he didn't know whether to answer or let it ring. In his lunch hour he ran out and bought an answering machine.

## Biggest Worry

The early days were tough. To keep things simple, he even considered being a cash-only business. Neither of those addressed his biggest worry: Business was slow, even though the overloaded practice at Highland was happy to send his former patients over. "There were days in that first year when the phone wouldn't ring," he recalls. "I would wonder: What have I done?"

Dr. Moore says his overall income after overhead costs was about \$80,000 that first year—half of it from his quality-of-health projects. That compares with about \$110,000 he made in the group practice.

His most expensive purchases for medical equipment were a new exam table for \$750, and an electronic thermometer for \$250. He paid \$100 to buy used furniture. While many doctors spend hundreds of dollars on wall-mounted eye- and ear-examining equipment, Dr. Moore says he pulled out hand-held versions that he used in medical school. His total outlay in that area was \$20, for a rechargeable battery. "I advise other doctors to buy the minimum of what they need," he says.

Initially, he didn't want to handle his own billing and insurance paperwork, because it would reduce time with patients. But he decided to pay \$250 a month for five years to use software that combines electronic health records, patient scheduling, and electronic billing.

He also bought off-the-shelf "disease management" software, called DocSite, to track how well his patients are doing on key measures, such as cholesterol, blood pressure and blood sugar levels. For example, the software easily generates a list of patients who failed to follow through on a blood-pressure checkup, alerting Dr. Moore to call or email those patients to come in.

### A Head Start

Once or twice a year, Dr. Moore asks his patients to complete a free Web survey called "How's Your Health." Developed by John Wasson of Dartmouth Medical School, the 10-minute survey is a series of carefully formulated multiple-choice questions about the patients' symptoms, medications, diet, past tests, emotional issues and habits, such as smoking and drinking. The survey evaluates the answers and converts them into a one-page snapshot of the patient's health. It also suggests links to relevant health Web sites, and can tell the patient how to track blood pressure, cholesterol or weight.

The snapshot gives Dr. Moore a head start before the patient steps into his office. The survey's wording leads many patients to indicate signs of trouble that they often wouldn't during a face-to-face visit, Dr. Moore says, giving him more clues to take action. When one heart patient wrote that he had begun drinking heavily, for instance, Dr. Moore referred him to a local alcohol-dependency center.

About a year ago, Susan Arazy filled out the survey and scheduled an appointment for a sore throat. Dr. Moore knew that diabetes ran in her family, and her latest health snapshot indicated that she wasn't following a healthy diet or exercising enough. It led to a discussion of her lifestyle and habits, recalls Ms. Arazy, and prompted her to join Weight Watchers and lose 35 pounds.

Ms. Arazy has multiple sclerosis. On a recent January morning, she

emailed Dr. Moore to schedule an appointment and got it for the same afternoon. She wanted Dr. Moore's opinion on whether early intervention with a drug called Avonex would slow her disease. Some research—dug up on the Internet by Ms. Arazy herself—suggested it could.

Sitting across from Ms. Arazy, Dr. Moore quickly confirmed her findings by logging into several Web sites from his laptop, including one run by the National Institutes of Health. That gave his patient confirmation that her question was worth asking a specialist. Dr. Moore then tapped out an electronic fax on his laptop and sent it to a neuro-ophthalmologist to arrange an appointment for Ms. Arazy.

In Dr. Moore's office there are no paper records. Letters from insurance companies and other documents are scanned into the electronic record, then shredded. All prescriptions are dispatched electronically to the pharmacy. In 2004 Dr. Moore expanded by renting a former storeroom next door that he now uses mainly to examine patients. He also hired a nurse to help him with his practice and grant work, but many micropractice doctors manage their own records.

Several years ago, Linda Lee quit a group practice and started a micropractice in a one-room office next to Dr. Moore. While she's happier now, Dr. Lee says she makes about 10% less. She also misses the paid vacation and free trips from her previous job at a group practice, which attracted more vendor-sponsored junkets and paid expenses for doctors to attend conferences.

When one of her daughters became ill, she fell far behind in her practice's paperwork. "I was worried whether I could keep it together," says Dr. Lee. Eventually, a patient who knew of her backlog was so concerned she sent her own daughter to help the doctor out.

Dr. Moore estimates that his overhead costs make up 35% of his revenue. That compares with a figure of about 60% for other small primary-care group practices, according to Medical Group Management Association, an Englewood, Colo.-based professional association for doctors' practices.

A few weeks ago, Dr. Moore asked patients to rate the medical care they receive by using the online survey, "How's Your Health." About 450, or three quarters of his patients, responded. About 70% said they had received the care they wanted, and at the time they wanted it. The national satisfaction rate, based on the same survey, is about 30%.

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**ONLINE TODAY:** WSJ.com subscribers can see a copy of the 'How's Your Health' form used by Dr. Moore and other micropractitioners, at [WSJ.com/OnlineToday](http://WSJ.com/OnlineToday)