



Shafer often had to stay late or go back after dinner to finish up paperwork—as here, in 1994.

For 16 years, I managed my husband's medical practice. The "Mom and Pop Doc Shop," I called it, because it was like an old-time general store where the proprietors lived in back and knew who would come in when, what they would buy, and when they would pay, if ever. Our office was never so quaint as to be attached to our house, but that never stopped patients from dropping by after hours for an informal consult. And, like a general store, it took both of us to run the practice.

Tim Shafer and I met in 1984, the year he arrived in Townshend, Vt., as a doctor for the National Health Service Corps (NHSC). The Corps—a program funded through the U.S. Public Health Service—had paid Tim's Dartmouth Medical School tuition in return for a commitment to work for three years in an underserved region. The NHSC's hope was that doctors would decide to stay and practice in the area where they did their service. But the two previous NHSC doctors posted in Townshend had left as soon as their payback period was over.

By the time Tim's three years were up, however, he and I were married and we'd put down roots in Townshend. We decided to stay, so the NHSC

ing the bill. After paying our employees' wages and benefits, after covering the rent and utilities, after buying the Band-Aids and cotton balls, we needed to have enough money left over to pay ourselves something. For 16 years we succeeded, though sometimes by the skin of our teeth. And then, on July 1, 2003, we gave the practice away.

Again, to Tim's patients, the change was seamless. The biggest changes were a regular paycheck and generous benefits for Tim, and freedom from working in health care for me. There had been significant changes in the way Tim practiced medicine during those 16 years, but far bigger changes in the operational arena—including debilitating governmental regulations and the health insurance industry's takeover of the delivery of primary care, introducing an excess of paperwork and a reduction in payments, which made staying independent and profitable ever more difficult.

Two other factors also contributed to our decision to close the "store." One, ironically, was the cost of providing health insurance for ourselves and our employees. The other was the invisible and intangible cost to our family.

This is the story of what happened, and how it affected us, in the years between 1987 and 2003.



Author Luskin, with Shafer—the doc shop's "Mom" and "Pop"—today.

CARE PACKAGE

Medicine is, at its core, the provision of care to patients. But in this country there's a lot of financial and regulatory baggage that goes along with providing care. Here is how one DMS alumnus—with more than a little help from his wife, running a "mom and pop doc shop"—handled that baggage.

STORY BY DEBORAH LEE LUSKIN PHOTOGRAPHS BY MAX AGUILERA-HELLWEG & FLYING SQUIRREL GRAPHICS

turned the practice over to us—lock, stock, and receivables. The only problem was that Tim was too busy doctoring to take care of the books. I, on the other hand, had just completed my doctorate in English literature and was unemployed and pregnant. We consulted a business advisor; started a checking account with \$2,000 in it; and, on July 1, 1987, opened for business.

To Tim's patients, the change was seamless. The office location and phone number remained the same, as did the staff. What changed was our need to turn a profit, since the Corps was no longer foot-

When Tim first arrived in Townshend, he was one of two family physicians covering the emergency room at Grace Cottage Hospital, a 19-bed outpost located an hour and a half southwest of Dartmouth-Hitchcock Medical Center. In addition to being one of two docs on call, Tim also took and developed whatever x-rays his patients needed, drew blood, ran simple lab tests, went on ambulance calls, and served as the regional medical examiner. All of those activities took time—time away from his clinical practice, which was what generated our income.



Above, reassurance during a house call. Below, a letter detailing Shafer's 1984 NHSC assignment.



Back then, the ambulance service was a volunteer affair and the ambulance itself a retired hearse. Tim often rode in back, offering what care he could on the trip up—to either Brattleboro, Vt. (20 miles away), or Dartmouth (60 miles away)—and catching what shut-eye he could in the empty gurney on the way back. In those days, before the widespread use of statins to treat high cholesterol and of clot-busting drugs to interrupt myocardial infarctions, heart attacks—as they used to be called—were a frequent occurrence. Little could be done besides wait them out and then transport the patient to Brattleboro or Dartmouth.

Yet today, heart attacks—and other formerly common emergencies—are rare events at Grace Cottage. Kevlar chaps protect loggers' legs from chainsaw blades, reducing the number who get rushed to the ER. Antibiotics and acid-reduction medications prevent bleeding ulcers, another once-popular cause of ER admissions. As a

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result, the number of hospital procedures Tim does for dramatic illness and injury has declined, while the amount of preventive care and disease management he provides in the office has increased—as has the cost of providing that care.

In 1987, few of Tim's patients had health insurance. Those who did were insured only against calamity; they carried major-medical policies that covered traumatic injury or illness after they'd met an annual deductible. Charges for the family doctor's care of injury or illness could be applied to the deductible, but charges for routine wellness care could not. So annual physicals and well-child visits typically had to be paid for out of pocket, setting patients back \$17—real money in the 1980s.

From a business point of view, the bookkeeping was fairly simple. As patients left the office, they paid their bill and were given a receipt to send to their insurance company for reimbursement. Except for Blue Cross Blue Shield, Medicare, and Medicaid, our office did not usually interfere in the patient-insurer relationship; we only provided health care. It is this that has dramatically changed.

We had inherited some aging receivables with the practice, so we bought one of the few medical software programs then on the market and became the first computer-users in the local medical community. The computer proved so much more efficient than the old manual system that we began billing insurance companies on behalf of our patients. Before long, we became intermediaries—running between insurer and subscriber in our effort to get paid.

The year we went into business, 1987, was also the year that managed care came to Townshend. Tim signed on to be a provider for the managed-care company, and in the early years our monthly capitation checks—a fixed payment we received for each covered patient—were often what carried us through. We bought this same managed-care plan to cover our employees and ourselves—all of us then under 40 and healthy. The premiums were less expensive than traditional major-medical coverage, and the out-of-pocket copay was just \$2.00, a fee all of us could afford.

At first, our business prospered and our family flourished. We quickly had three healthy children and, between the two of us, were earning a comfortable salary by local, if not medical, standards. My job at the office was part-time, but Tim worked 12- to 14-hour days and covered the ER at Grace Cottage Hospital every third night. He also delivered babies. There were days when he didn't see his own babies. As his schedule became increasingly onerous, he yearned for family time. I craved his companionship and partnership in parenting.

Neither of us recalls those years in great detail. We adjusted according to our needs: I learned to sleep through the phone ringing in the night; Tim learned to sleep through the kids' nighttime cries. We were too tired to question this division of labor, though there were times I wondered how I'd ended up as a bookkeeper with a Ph.D. in English.

We had been incredibly fortunate to start off without debt; it is unlikely we could have managed if we'd had loans to pay off. Our financial status changed in 1990, however, when we outgrew our rented office space. Unable to afford a commercial mortgage, we were lucky to negotiate a family loan.

We bought and renovated a former restaurant building. Our expenses soared and our income plunged. In addition to keeping the books, I now cleaned the office at night, and Tim took the trash to the dump. Tim also started seeing more patients every week. We trained our patients to make their copays at the door. We upgraded our computers and instituted electronic billing to insurance companies. We started accepting credit cards. We hired a collection agency to pursue bad debts.

Collecting bad debts has to be one of the worst jobs in the world, and fairly futile in health care. Most of those who didn't pay couldn't, and there is little one can do about the few who simply won't. A good 95% of our patients paid their bills. The 5% who didn't were almost all treated in the emergency room—people who had either no insurance, no address, or no intention of paying even if they could. This is an example of the kind of cost-shifting routinely practiced in health care; in this case, the cost of caring for the uninsured was shifted to the physicians who treated them. Unfortunately, in the fee-for-service model, trying to collect from this often fragile and usually transient population was the only way for Tim to be paid for his nights and weekends on call. So the work that cost him—and his family—the most in terms of his own health and happiness paid him the least.

Our children would ask, "Is Dad on call?" on the nights when Tim wasn't home by bedtime. If we hadn't seen him in a few days, we'd visit the hospital and join him there for a meal, or stop by the office and raid the pediatric drawer for stickers. Tim wanted to be with his children and would rush home to give them their baths whenever he could. Then, after stories, songs, and goodnights, he'd return to the office to finish his charts. Three years after we moved into the new building, Tim was working harder, he had less family time, and our income had still not recovered. Yes, we had built equity, but equity didn't buy our kids milk at the store.



Shafer today, making rounds on inpatients at the 19-bed Grace Cottage Hospital in Townshend, Vt.

IN 1990, OUR EXPENSES SOARED AND OUR INCOME PLUNGED. IN ADDITION TO KEEPING THE BOOKS, I NOW CLEANED THE OFFICE AT NIGHT, AND TIM TOOK THE TRASH TO THE DUMP.

My father, a successful businessman, had counseled us that there were only three ways to increase profit: cut costs, increase productivity, or raise prices. We'd done the first two and, in the highly regulated health-care industry, there were strict limits on what we could do about the third.

Medicare and Medicaid accounted for half of Tim's practice—or payor mix, in the lingo of the jargon-laden industry. Medicare and Medicaid are government-funded insurance, and in our fee-for-service system the government sets the price it will pay and then takes a 20% discount from that price. On my most exhausted and cynical days, I proposed that after we figured our federal tax liability, we should deduct 20% from what we owed. Just the idea cheered me up.

There was a way to improve our Medicare and Medicaid reimbursements—if we were willing to take on the added work of becoming a Rural Health Clinic (RHC). The RHC program had been established in 1977 to address an inadequate supply of physicians serving Medicare and Medicaid beneficiaries in rural areas. Like the National Health Service, which brings physicians to medically underserved areas, Rural Health Clinics aim to keep them



Above, hands-on care in the office. Below, the \$15,542 quote for the office's first computer system.



there. After considering our options—most of which included packing up and moving—we hired consultants, borrowed money to pay them, and applied to be an RHC.

Though it was a program designed for small, struggling, rural practices, we had to write a policies and procedure manual befitting a Fortune 500 company and draw up an organizational chart. Every function had to have a job title and a job description. With only five employees, several of us had more than one. Tim was Owner, Medical Director and Laboratory Director, Trash Hauler, and Snow Remover. I was Practice Manager, Head of Human Resources and Information Technology, Director of Facilities, and Safety Officer. I even had to conduct an annual fire drill—and document it.

Over time, we learned how to fulfill the often redundant, sometimes opaque reporting requirements of being an RHC. We also learned that though we had strict deadlines for our reports—with interest and penalties if we failed to meet them—Medicare and Medicaid could take forever to audit our reports and always did. Nevertheless, for several years we were able to pay our bills, pay an office cleaner, pay ourselves, raise wages, and fund a profit-sharing plan for retirement.

We became an RHC in 1994, a watershed year for two other reasons: Tim stopped delivering babies and a fourth doctor came to town. Unlike the three other local family practitioners, however, this

physician was not in private practice but was an employee of the hospital.

When I met Tim in 1984, he was one of just two doctors covering the ER at Grace Cottage. When he asked me to marry him, I said, “Yes—when there’s a third doctor in town.” The third doctor miraculously materialized the following year, and the three of them had shared call since then.

There had been room for a fourth for some time, but it was a tough sell. Sometimes physicians would stumble across Grace Cottage when they were vacationing in southern Vermont; others heard about this tiny hospital through the medical grapevine. Whenever doctors expressed interest in setting up shop in town, we’d have them over for dinner—one couple trying to seduce another to join an unquestionably good life, which would be so much better if only there was one more doc with whom to share call.

The way Tim practiced medicine was very appealing: he was his own boss, he treated whole families, he made house calls, and he was part of the social fabric of the town that he served. Other bonuses included a two-mile commute and casual dress every day of the week. Our small-town life was bucolic: we lived in an antique cape, grew lots of vegetables, tended a flock of chickens, kept bees, and even raised our own pig. We were part of a community. We also lived smack in the midst of New England’s beauty and could snowshoe out our back door or be in the Green Mountain National Forest within minutes.

These dinners were always a great success, followed by the inevitable morning-after of financial truth. We could barely pay ourselves, let alone hire another physician. Short of finding a doctor with enough savings to be self-sustaining for an indefinite time, in anticipation of an uncertain income, we just could not persuade anyone to join us.

After two promising prospects bowed out, the Grace Cottage administration stepped in and hired a doctor—paying a salary and providing benefits, an office, and staff. Once there were four docs in the call schedule, and a guaranteed living wage, working in Townshend became more attractive. Shortly thereafter, the hospital hired a fifth doctor, then a sixth. For one spell, the call schedule included seven physicians, but that didn’t last.

By that time, most insurance policies covered some wellness care—a benefit designed, in theory, to encourage better health maintenance. In fact, what these plans did was shift the administration of the benefits to the physician’s staff. In our small office, we would submit claims on behalf of our patients in order to be paid by their insurers. The increased expenses associated with this billing—in

time and technology—were never reimbursed; they simply took a bigger bite out of every dollar that came in.

At the same time, our patients often didn't understand how their managed-care policies worked. Our staff worked hard both to educate them and to work the system in our patients' favor. But it is not easy arguing with an automated answering system or explaining to a human drone that it's burdensome at best, and sometimes impossible, for patients to get to the company's one networked mammogram site in Burlington, three hours away.

Different insurance companies and different policies also covered different services. Our staff researched the various policies to find out what a given patient's coverage would allow Tim to do. So instead of Tim providing the care his patients' conditions required, he was providing the care his patients' insurers allowed.

We were blessed with employees who worked hard for our patients and were loyal to Tim and forgiving of me. The "Ladies," as we called them (they were all women), really ran the joint. They knew our patients well and so knew who needed to be seen immediately. They could squeeze 75 minutes into every hour. Working together in a tight space, however, they could also get on each other's nerves. They would complain to me about one another. In the early years, I'd jump in and try to fix things, bruising feelings along the way. Over the years, I learned that all I really had to do was listen.

I also resented our employees' annual raises in the early years. As we worked together, however, I came to appreciate these women, wished I could pay them more, and considered them our allies. Nevertheless, the economic reality was that their hourly wage was only about half the cost of their employment to us. Wages triggered taxes for social security, Medicare, worker's compensation, and unemployment. In addition, they each received six paid holidays and two to three weeks of paid vacation. We also offered other benefits, such as paid lunches, profit sharing, and health insurance.

Too often, the "Ladies" chose to forgo raises in return for full payment of their health insurance premiums, which rose yearly. To stay ahead of the curve, we kept switching to policies with higher co-pays and higher deductibles; the business picked up employees' out-of-pocket costs after the first \$200. In our penultimate year in business, three employees met the \$2,500 deductible. It was a very lean year for us.

It was also a year of more than usual staff illness and absence from work. So in addition to my management duties, I was filling in wherever I could.



Shafer today, in front of Grace Cottage Hospital in midsummer—high season for ER visits there.

THE RHC PROGRAM WAS DESIGNED FOR SMALL, STRUGGLING, RURAL PRACTICES, BUT WE HAD TO WRITE A POLICIES AND PROCEDURE MANUAL BEFITTING A FORTUNE 500 COMPANY.

Some patients loved it when I answered the phone and enjoyed chatting with the doctor's wife; others, understandably, didn't want me involved in their care. And I didn't want to be there.

When we married, Tim and I made a pact not to stifle each other. Once the kids were in school, despite the demands of the medical practice, I had managed to draft two novels, publish a number of articles, and teach on a limited basis. Those were things I was good at; I was not as good at answering the phone. And posting payments and processing paperwork only heightened my awareness of how fragile our finances were again becoming.

But it wasn't just the finances. We probably could have accepted the grim realities of declining income, unpaid vacations, inadequate retirement savings, and expensive health insurance if it hadn't been for two things: summers and HIPAA.

Summers had always been difficult. The kids, home from school, needed us. Even if we could have afforded summer-long camps, we didn't want to send our kids away. While the problem of finding good summertime child care is not unique to medical families, the unpredictability of Tim's

An 11th-hour reprieve for small establishments gave us an extra year before we had to have all our forms in place. But I didn't see how another year would make any significant difference to the bottom line. Complying with HIPAA would have required us to retool our information technology yet again. It would hold us all, individually and collectively, accountable for noncompliance, including fines and criminal charges. More than once I wondered who was writing these laws!

Officials in Washington were writing these laws and, briefly, in the winter and spring of 2003, I was talking with people at both the state and federal level about turning our little RHC into a Federally Qualified Health Center (FQHC). This would have made it the hub of a network stretching across at least two counties in southern Vermont. It would have been a huge undertaking—thrilling and scary and much more interesting than trying to figure out how to implement HIPAA. I purchased a power suit from the local thrift shop and wore it to a few meetings. It just didn't fit.

I didn't want to be a health-care administrator, nor did Tim and I see how we could support ourselves through another bureaucratic transition. So I made one more attempt to understand HIPAA. I'm trained to read closely, to see both text and subtext. What I saw in the language of this law was an Orwellian corruption of meaning. The Privacy Rule presents itself as a means of protecting sensitive health information, but what it really does is grant government, law enforcement, and insurance companies access to patients' personal health records. This was not a game I wanted to play.

Instead of putting HIPAA in place, we entered negotiations with Grace Cottage to take over our practice. At the end of the day on June 30, 2003, we closed up shop. The next day, Tim was there as usual, but as an employee of the hospital.

It was hardest on our staff. Even though the hospital matched their wages, offered them more and better benefits, and transferred their years of service, they were used to working for us, and that changed. "It was like a family," one former employee recently told me. "Our patients were like family. Our coworkers were like family. I really miss it." Over the years, this woman had served as a receptionist, bookkeeper, substitute office nurse, insurance coder, and bill collector—sometimes all in the same day. Now she's a certified medical billing specialist and that's all she does, in an isolated cubicle, every working day.

To my surprise, I sometimes miss it, too. I don't miss my Wednesday night pillow talk with Tim, which was always about whether or not we'd make



Shafer and Luskin today with their bee hives—one of the many pleasures of living in a rural area.

WITH THE BEES BACK IN THE HIVE AND THE KIDS BACK IN SCHOOL, I FACED THE TASK OF TRYING TO UNDERSTAND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

Thursday's payroll. I don't miss the cost reports; I prefer not knowing who owes money for care. But I do miss our former staff and our teamwork—the way we all pulled together to provide excellent, personalized care for our patients and for each other. I've moved on, however, to a growing career as a freelance teacher, researcher, and writer (often writing about physicians and medicine).

For Tim, what has changed is that he now has a regular paycheck and the freedom to practice medicine without the headaches of running a business as well. Otherwise, much remains the same. He has paid personal days and sick days but has yet to use one. He is still on call too often, is late for dinner more often than not, and invariably works several hours on his days off. Since signing on with Grace Cottage, he has been named Medical Director and so spends countless hours in meetings as well.

But what has not changed is that Tim is still there, doing what he does best: giving patients his whole attention and providing them with the kind of primary care that takes good listening skills, sharp powers of observation, deep knowledge of a patient's medical as well as social history, and time to give comprehensive care. ■